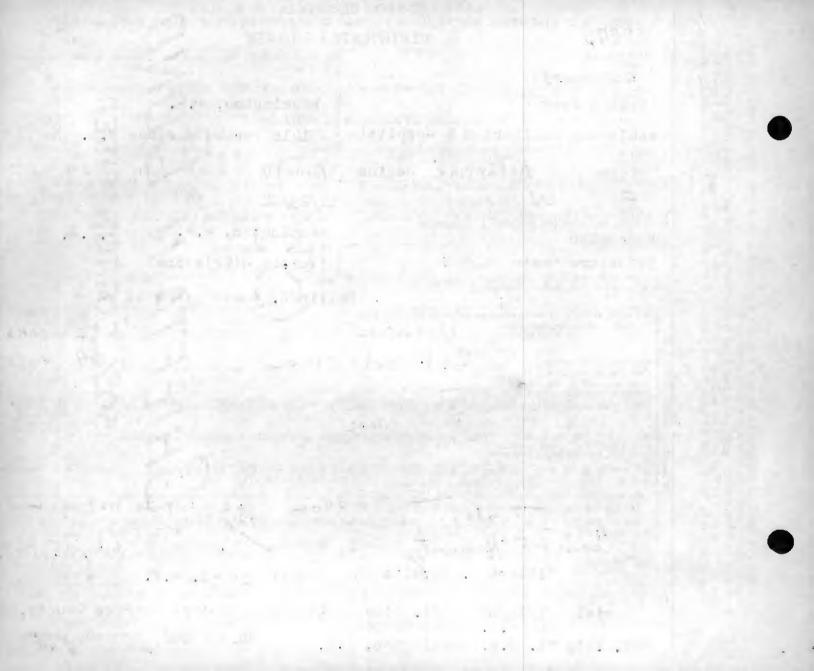
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09671 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Michigan Mentone ro ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours often CITY OR TOWN (If outside carparete limits, write RURAL and give nearest town) CLENGTH DE STAY IN 16 c. CITY DR TOWN (If gutside corporate limits, write RURAL and give negrest town) Rockvi/1/le d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE d. STREET ADDRESS Van Dyke Place ON A FARM filled Valley/Nursing Potromac/ 3 NAME OF 4 DATE Year campietely DECEASED carb (Type or print) DEATH 19 SEX 6. CDLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HR AGE (In years NEVER MARRIED last birthday) Months Dovs Hours April 13,1891 and in any DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT physician a ien please Auring most of working life, even if retired)
Retired-Account ant Accounting COUNTRYS Michigan 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remayal, unknown Henry Adams 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT &ddress. (Yes, na, ar unknown) (If yes give war ar dotes af service) 374-16-3082 Betty Berry Red Barn La., Potomag no crematian, 1B. CAUSE OF DEATH (Enter only one couse per line far (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEET ONSET AND DEATH burial-transit . IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause by the haspital ar attending as the WAS AUTOPSY PERFORMED? has PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT TERMINAL DISEASE CONDITION GIVEN, IN PART 1(0) Health NO certificate TO 20g. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH d. detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (Caunty) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) While Not While at wark 21. I certify that (1) (this hospital) ottended the deceased from June 12, 1967 to 7-7-, 1967, that (1) (me) last saw the deceased alive an June 30 1967, and that death accurred at ZTM, from causes and on the date stated above TO HOSPITAL OR ATTENDE Page 4 may be retained TO FUNERAL DIRECTOR: A be retained 200 SIGNATURE 22b. DATE SIGNED DIRECTOR Murus M.D. r, page 3 be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) FRYAME! 16011 directar, shauld b 23c. NAME OF CEMEJERY OR CREMATORY 23g. BURIAL CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Elmwood Cemetery July 13, 196 Detroit. Michigan 256. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR 250. REGID BY REGISTRAR VR A15 (4) 25M 1/67 BETHESDA, MARYLAND PUMPHREY

CT. TO DATE TO And the state of t CONTRACTOR TO TAN SELECTION OF THE PROPERTY OF THE PARTY O passion and ethickers that make at the contract the state of the s Land Translation of the THE REPORT OF THE PROPERTY OF THE THE WAS TOUGHT THE THE THE

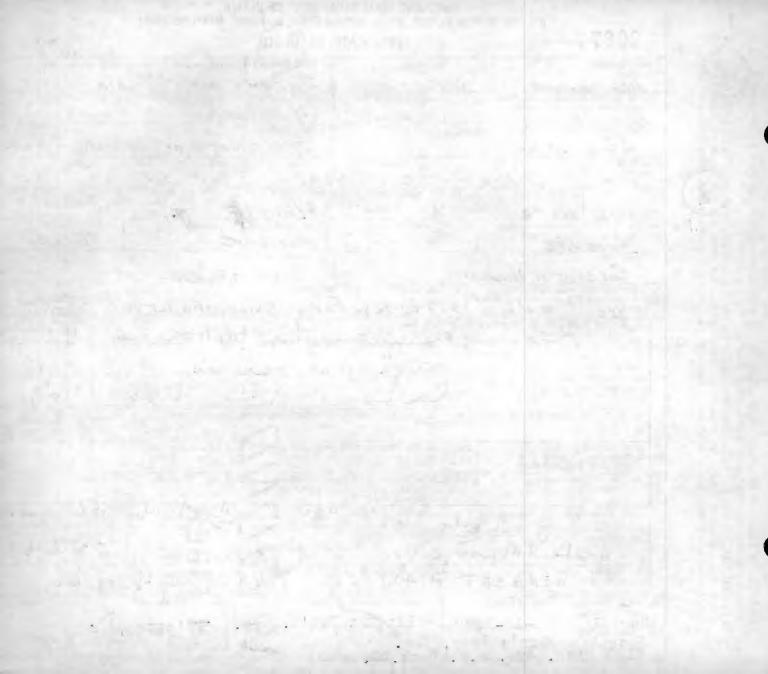
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09672 09677 CERTIFICATE OF DEATH executed within 24 hours ofter death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) funer 1 of o. COUNTY o. STATE b. COUNTY MONT GOMERY MONTGOMERY MARYLAND MARYLAND Pages b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) ROCKUILLE SPRING SILVER d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 11424 SCHUYLKILL CROSS YES NO V DATE OF DEATH NAME OF Middle Lost Year DECEASED DROTH Y LUANOS (Type or print) IF UNDER 1 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years lost birthday) Months Dovs Hours WHITE WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY attending physician permit. Then please and JERSEY NEW U.S. H 13. FATHER'S NAME or removol. Dora Schoeler GENTZEL 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service DAUGHT ER DOROTHY PELUSO NO cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per Jinge I-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO for use as the l stoting the underlying couse ottending last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH of (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While of work 21. I certify that (I) (this haspital) attended the deceased fram be retained M. from causes and on the date stated above. and that death occurred at saw the deceased alive on\_ 22b. DATE SIGNED 220. SIGNATURE DIRECTOR M.D. FUNERAL director, should by 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City. 230. BURIAL CREMATION 23b. DATE THEREOF (County) Cremation 7/12/67 Frince George Co., Maryland Cedar Hill 0 Wheeler Funeral Home-1331 Rockville Pike VR A15 (4) 25M 1/67 Rockville. Maryland

97622 ST072 STATES SALVES HOLLA GLESS PREDICTION THREE SEPTIMENTE PEHALE WHITE X 5/11/92 15 des enployed the description of the H ERNST GENTZEL CENTLED TOWNSHIPS NO ( STR-SLABOLTHUSHTER : DORTHY RELUGIO Annual Control of the Annual Control of the Control

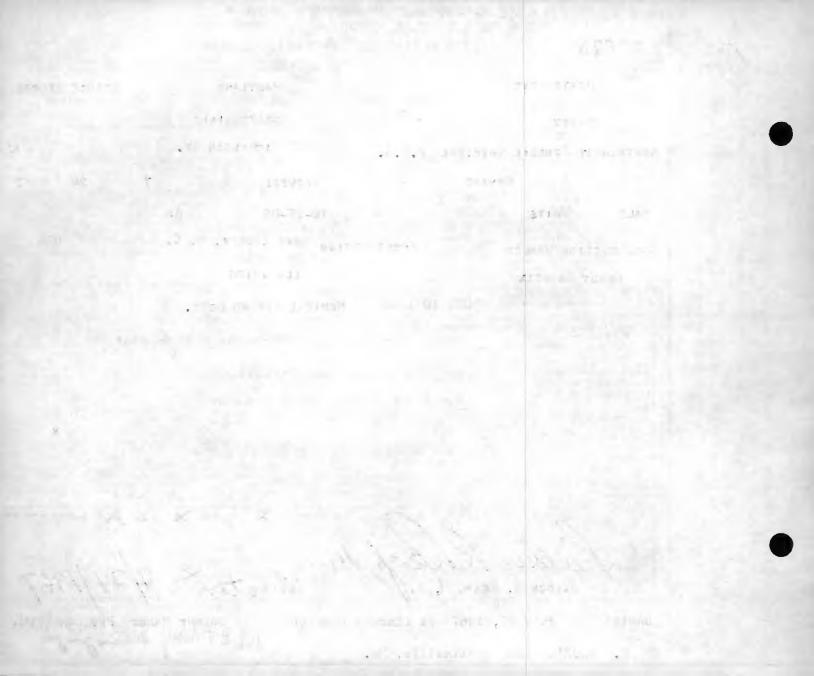
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE b. COUNTY Montgomery MARYLANO b. CITY OR TOWN (if outside corporate limits, c. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) Takoma Park Washington, D.C. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET AOORESS e. IS RESIDENCE ON A FARM? Washington Sanitarium & Hospital 1116 Parkwood Place NO executed within completely 3. NAME OF Middle Oay DECEASED OF DEATH Regina Amat (Type or print) 19 5. SEX OATE OF BIRTH ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIEO NEVER MARRIEO Last birthday) Months WIDOWED ( DIVORCED ! 10a, USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY during most of working life, even if retired) Washington, lomemaker death certificate 14. MOTHER'S MAIOEN NAME 13. FATHER'S NAME attending phy ermit. Then p n, or removal, Amato Teresa DiCristina Salvatore 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | (ff yes give war or dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. the attendit Phikip J. Amato same as INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed been street the burial, r DUE TO eroderma Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO IZ YES ZOA. ACCIDENT WAS UNDERLYING TO CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury In Part I or Part II of Item 18.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20f. (City or town) Hour a.m. Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from IUne T FUNERAL DIRECTOR: / lirector, page 3 should hould be filed with the 19.6.7, and that death occurred at 4:20 p.M. from the causes and on the date stated above. saw the deceased alive on 22b. OATE SICNED 22a, SICNATURE OIRECTOR \_\_\_ 22d. AOORESS PHYSICIAN'S director, p NAME (Type) Gilbert 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Prince Georges County, Mc Ft. Lincoln Cemetery buria 25a. REC'D BY RECISTRAR | 25b. REGISTRAR'S SIGNATURE Hines ADD Sapany Washington. VR A15 (4)



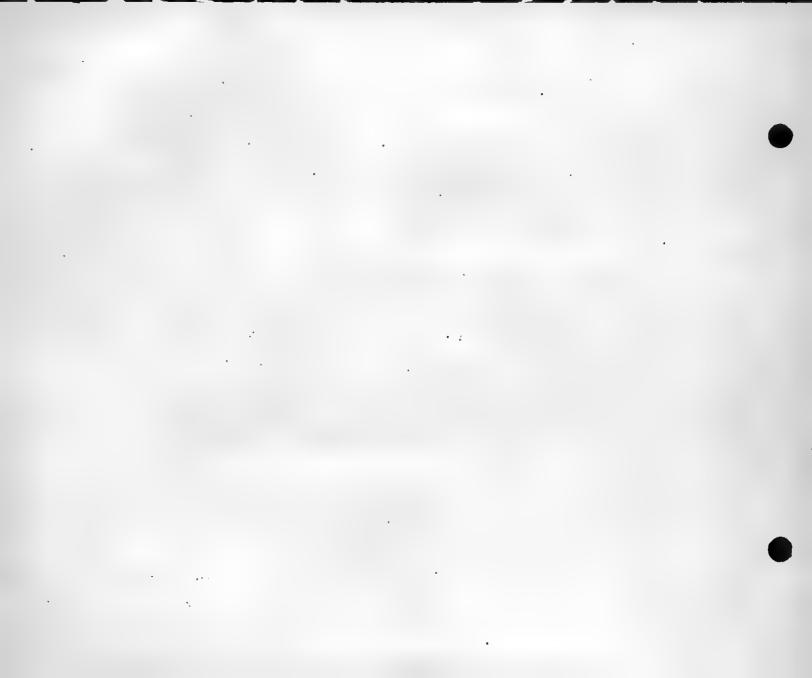
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09674 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, MARYLAND DISTRICT Columbia of requires that the death certificate be executed within 24 hours ofter. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. Pag hin 72 hours o write RURAL and give nearest town) ETHES DA IN ASHINGTON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS filled SUBURBAN MILL WOOD YES NO X NAME OF Middle DATE First Last Year DECEASED JAFFA NULL 1967 (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. CDLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs WIDOWED X DIVORCED WHITE 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT during most of working life, even if retired) ENDUSTRY COUNTRY? S. A -MARYLAND HOUSEWIFE 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ANNA MITURNER 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 5000 MILLWOOD (Yes, no, or unknown) (If yes give wor or dotes of service) 50 FRANCIS GLOVDAWALT, JR. W.W. 7 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), buriol-transit PART I. DEATH WAS CAUSED BY DISET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed | Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse the OR ATTENDING PHYSICIAN: The law lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) has NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc, TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. While Not While foctory, street, affice bldg., etc.) ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram was 190 and that death accurred at 7 A. M. fram causes and an the date stated above saw the deceased alive an DIRECTOR: 22o. SIGNATUR! 22b. DATE SIGNED, M.D. PHYS. DIRECTOR PHYS director, page 3 should be filed 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (Chy or Town) (County) REMOVAL (Specify) Arlington 250. RECTO BY REGISTRAR THE SUPPLIFIER S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS Sons, VR A15 (4) 25M 1/67



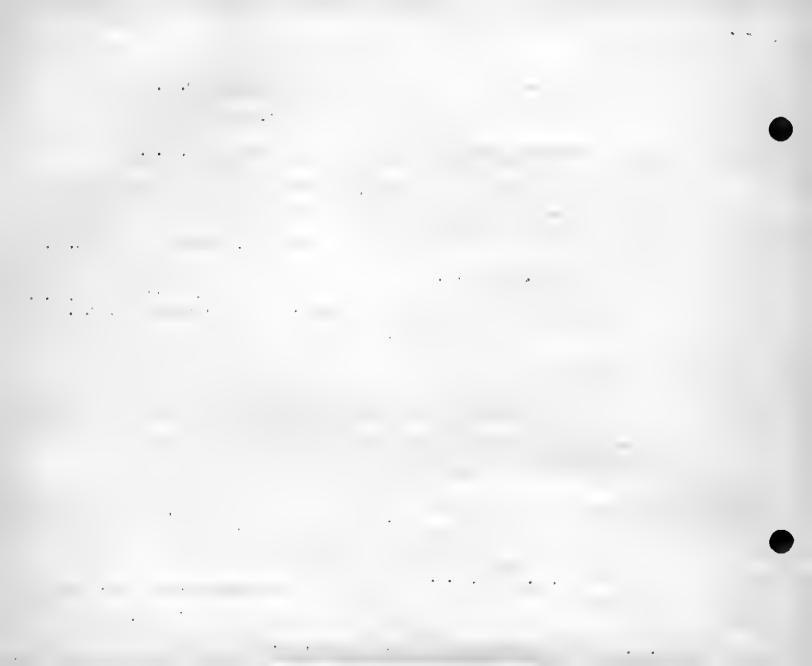
Tt	tems 18&2	Pilm 39:	OF VITAL R	ARYLAND STATE DEI ECORDS, 301 W. PREST	PARTMENT OF HEADNL STREET, BALTIM	ALTH DRE, MARYLAND 21	201		
	0967	Lten		ICAL EXAMINER'S	o o on			09680	
I. 1	1. PLACE OF DEATH O. COUNTY MONTGOMERY MARYLAND				o STATE	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)  o. STATE  MARYLAND  PRINCE GEORGE			
	b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town)  OLNEY			LENGTH OF STAY IN 16 DOA	HYAT	utside carparate limits, wri	te RURAL and give	-2	
		ALOR INSTITUTION (IF I			d. STREET ADDRESS 3904 NICH	IOLSON ST.		e. IS RESIDENCE ON A FARM? YES NO	
3.	NAME OF DECEASED (Type or print)		R YANT	Middle	Lost BAGWELL	4. DATE OF DEATH	Month 7	Doy Year 24 19 67	
S.	MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 10-26-05	9. AGE (In ye lost birthd	oy) Months yrs.	Doys Hours Min.	
du	iring most of working	(Give kind of work done life, even if retired) TON WORK ER	INI	ND OF BUSINESS OR DUSTRY CONSTRUCT	11. BIRTHPLACE (Stote	or foreign country) UNTY, N. C.		UNTRY? USA	
	3. FATHER'S NAME	Y BAGWELL			14. MOTHER'S MAIDEN ELLA SM				
1:	S. WAS DECEASED EV Yes, no, or unknown)	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address MEDICAL RECORD DEPT.							
	18 CAUSE OF D PART 1. DEA  LACA Conditions, if ony rise to immedia stoling the under	which gove )	(o) A C 10 (b) 8 r	(o), (b), ond (d)) cute coronary ad old myocar oronary arter	dial infar	ction;	ecent	INTERVAL BETWEEN ONSET AND DEATH	
ATION	PART II OTHER S		CONTRIBUTING T	TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	NDITION GIVEN IN PART I	(a)	19. WAS AUTOPSY PEREORMED? YES NO	
CFRTIFICATION	206. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTION CAUSE OF DEATH.								
MEDICAL	20c. TIME OF INJ Hour o.	URY Month, Doy, Year m. m. 19	20d. IN While of work	- Not While - fo	ACE OF INJURY (Home, for ctory, street, office bldg., etc		wn) (Cou	unty) (State)	
	21. I certii deoth resul ACTUAL SIGNATURE EXAMINER'S NAME (Type) 30. BURIAL, CREMATI BENOVAL (Pecif 24. FUNERAL DIRECTI	BELDEN R.  ON, 236 DATE THE July 2'	REAP,	Me D. A  23c NAME OF CEMETERY O	CHIEF MEDICAL  M.D. ASSISTANT ME  DEPUT MEDIC  AUGUST  R CREMATORY	L EXAMINER DICAL EXAMINER DICAL EXAMINER	7/24 ortown) anor pr	22. DATE SIGNED  (County) (Stote)	
3			Hyatt	sville, Md.	DATE		CHONCA	Amy-	



	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RYLAND
= =2:	09676 Certificate of Death	2581
death. funeral and 2 r death.	1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY  a. STATE  D. COUNTY	idence before admission
rs after by the f Pages 1 Irs after	b. CITY OR TOWN (If outside corporate limits) c. LENGTH OF STAY IN 1b write RURAL and give rearest town)	nd give nearest town
in the Proof	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE
filled i	Montgomery Co Gen. Hosp. 3804 Washington ST	ON A FARM? YES NO K
executed within 24 had and completely filled emove carbon papers any event, within the	3. NAME OF DECEASED (Type or print) A / EXAMPLE FIRST Middle Last 14. DATE Month DF DECEASED (Type or print) A / EXAMPLE FOR THE DEATH JULY	Oay Year
executed wi and comple remove cart	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER I) Months 0	
n and remin and in an	WIDOWED   OIVORCED   Job   Justice   Olivorced   Oli	IZEN OF WHAT
physician n please	Bost Mar. Ment. Co. Liquer Boscel MICh Agas	U.S.
certifical	13. FATHER'S NAME  FRANK BANCH  SALOME FORME	ナ
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, nor unknown) (If yes give war or dates of service)	
the denation	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
at the sian. Side of the side	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL THERETON	day
The law requires that the death or attending physician. Sate has been signed by the atteres as the burial-transit permisalth prior to burial, cremation, controls.	conditions, If any, which ) OU ARGERIOSCLEROTIC IDEART DISEASE	YENS
CIAN: The law requirespital or attending scrifticate has been had for use as the t. of Health prior to to	gave rise to immediate ( cause (a), stating the DUE TO underlying cause last. (c)	
law reattendii has be e as th	F PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
N: The la tal or att ifficate h for use Health	208. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  CONTRIBUTING   CAUSE OF DEATH (I FITHER, NOTIFY MEDICAL EXAMINER)	YES NO K
YSICIAN e hospita ils certit tached f	208. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician.  FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cre-	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20f. (City or town) (Count factory, street, office bldg., etc.)	ty) (State)
ENDIN ined to R: Aff ould b	21. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 7/16 , 1967	
r eta reta ECTO 3 sho with	22a. SIGNATURE 22b. DAT	TE SIGNED
AL OR lay be lay be page filed	22c. PHYSICIAN'S DIRECTOR PHYS. 17/12	167
Fage 4 may be retained to FUNERAL DIRECTOR: A director, page 3 should should be filed with the	NAME (TYPE) RICHARD H. POLLEN 10400 CONNECTICUT AND KENS	anean, Mo
TO HC Page dire shou	233. BURIAL, CREMATION, 23b. DAYE THEREOF 23c. NAME OF CEMETERY OR PREMATORY 23d. LOCATION (City, town or countries of the contribution of the countries of the coun	148.
VR AIS (4)	24. FUNERAL DIRECTOR ADORESS ADORESS JUL 250. REGISTRAR 25b. REGISTRAR'S THORE JUL 25 1967 Floore	SIGNATURE SURFACE
20M 1/65	Thursday of the state of the st	



1 1	Division of STATISTICAL RE	MARYLAND STATE DE SEARCH AND RECORDS, 301	PARTMENT OF HEA W. PRESTON STREE	ALTH T, BALTIMORE, MARYLAND	21201
0967	7	CERTIFICATE	OF DEATH		99683
1. PLACE OF DEATH a. COUNTY	V	MARYLAND	o. STATE	nere deceosed lived, if institution R b. COUNTY	· ·
write RURAL one	Montgomery f outside corporate l'mits, l give neorest town) Bethesda	c. LENGTH OF STAY IN 16		ngton D. C.  ide corporate limits, write RURAL or  ict of Columbia	nd give neorest town)
d NAME OF HOSPIT.	AL OR INST TUTION (If not in hospite	ol, give street oddress)	d. STREET ADDRESS		e IS RESIDENCE ON A FARM?
3 NAME OF	Naval Hospital	Middle	1_4605_47th	Street N.W.	YES NO Year
DECEASED (Type or print) S SEX	Lee 6 COLOR OR RACE 7 MARRI	Winthrop  ED NEVER MARRIED A	Barnes DATE OF BIRTH		
Male  100 USUAL OCCUPATION during most of working		ED DIVORCED KIND OF BUSINESS OR INDUSTRY	28 July 196	7 Yrs	12. C TIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	,		Bethesda  14. MOTHER'S MAIDEN NA	Maryland	U.S.
(Yes, no, or unknown)	(If yes give wor or dotes of service)	None Jo	NFORMANT	Ellen Davenport 4605 47th s Jr. Washingto	INTERVAL BETWEEN
Conditions, if ony rise to immediat stoting the underlost.	TH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  DUE TO  which gove e couse (o), elying couse  (c)	rematurity			ONSET AND DEATH
ATION		IG TO DEATH BUT NOT RELATED TO			19. WAS AUTOPSY PERFORMED? YES NO
	☐ CAUSE OF DEATH MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRED.			16
Hour o.i	π. 19 of	hile Not While of foct	E OF INJURY (Home, form, pry, street, office bldg., etc.)		(County) (Stote)
21. I certi saw the d 220. SIGNATURE	eceased alive on 29 Ju	tended the deceased from 2 1y 19 67, and tha	t death accurred at	**30PM, from causes and	an the date stated obov 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type		M.D.	PHYS. LI	DIRECTOR L.J. PHYS. L.J.	31 July 1967
23a. BURIAL, EREMAND REMOVAL (Specify	DAN, 23b DATE THEREOF	23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City or Town) ry Arlington,	(County) (Stote) Virginia
24. FUNERAL DIRECTOR R. A. Pum	IP .	ADDRESS onsin Ave. Bethe	2Sq. REC D	BY REGISTRAR J. 25b. REGISTE	RAR'S SIGNATURE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00683 CERTIFICATE OF DEATH 0967 requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MARYLAND mont gomery c. LENGTH OF STAY IN 16 c. CITY OR TOWN (Woutside corporate limits, write RURAL and give neggest town TOWN (If outside carparate limits) write RURAL and give nearest town) DER TON d. NAME OF HOSPITAT OF INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? omprefely filled in papers. YES 🗌 NO 🔽 3 NAME OF the ottending physician and compretely f sit permit. Then pleose remove carbon Middle 4. DATE Month Doy Year First DECEASED Baby Boy 19 DEATH (Type or print) IF UNDER 24 HRS 9 AGE (In years IF UNDER 1 YEAR S SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 8. DATE OF BIRTH lost birthdoy) Months nours or removal, and in ony WIDOWED DIVORCED 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 100 USLAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR during most of working ife, even if retired) TT SOUNTRY? Infant Montgomery--Md. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Barnwell 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT buriol-transit permit. (Yes, no, or unknown) (If yes give wor or dotes of service Vincent Barnwell-father-same item # 2 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c))
PART | DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the hospital or attending Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been os the 19. WAS AUTOPS' PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) or use YES 🔲 NO 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg. etc.) ot work ot work 21 I certify that (1) (this haspital) attended the deceased from JULY 31, 1967, to JULY 31, 1967, that (1) (we) last 1967, and that death accurred at & A. M. fram causes and an the date stated abave. saw the deceased alive an JULY 31 22b. DATE SIGNED 220 SIGNATURE ATTENDING MD DIRECTOR 22d ADDRESS 22c. PHYSICIAN S NAME (Type) 230. BUR-AL, CREMATION, REMOVAL (Specify) (County) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) Gate of Heaven Cem. Silver Spring Burial 250. REC'D BY REGISTRAR 1331 Rock. Pike er Funeral Home VR A15 (4) 20 M 1/66

Rockville.



VR A15 (4) 20M 1/65

25a. REC'D BY REGISTRAR 196

25b. REGISTRAR'S

e. IS RESIDENCE ON A FARM?

NO 🔀

YES

12. CITIZEN OF WHAT

A2

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

PERFORMED?

YES

(County)

22b.

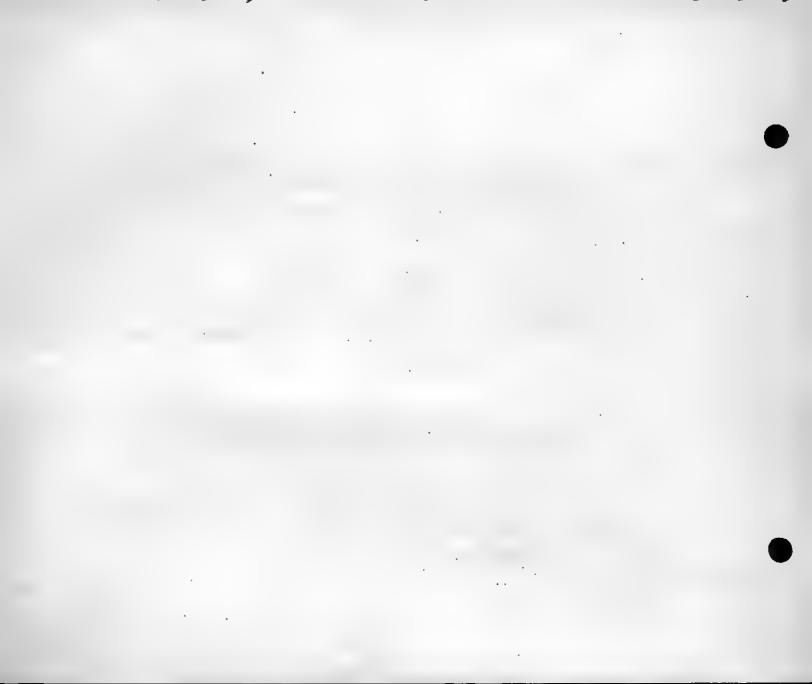
OATE SIGNED

NO V

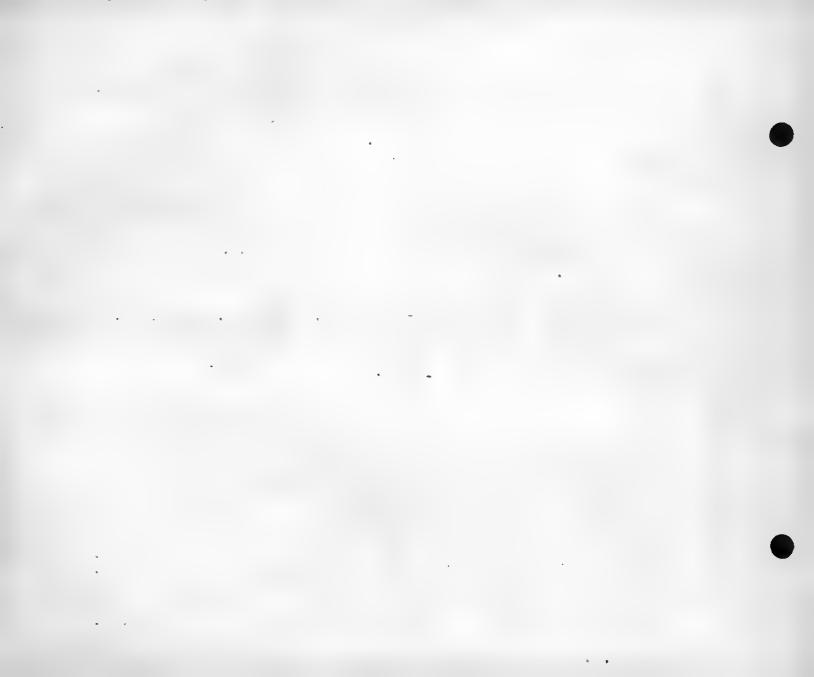
(State)

(State)

COUNTRY?



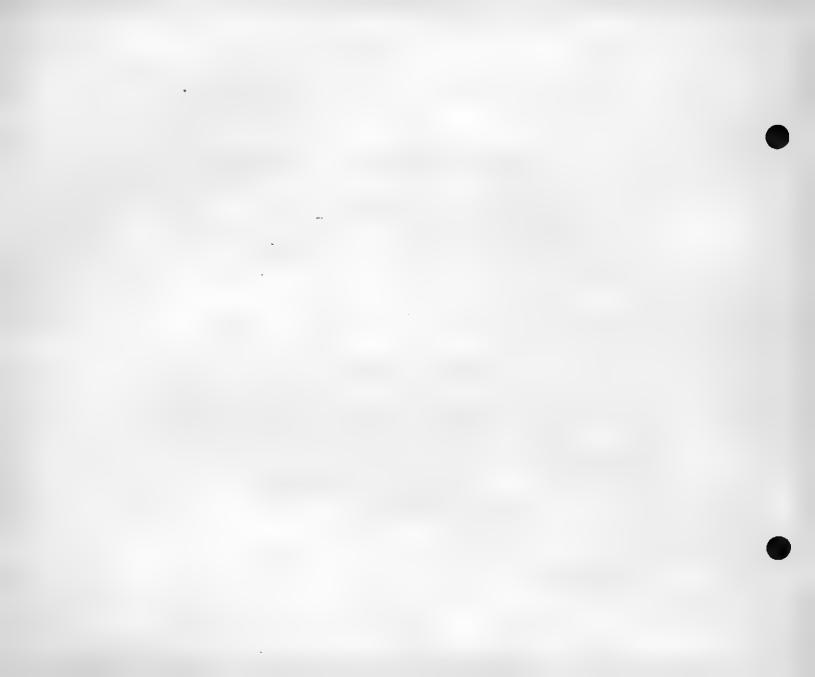
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08685 CERTIFICATE OF DEATH 09570 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY Montgomery MARYLAND Marvland Prince Georges b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 write RURAL and give negrest town) West Hyattsville Wheaton d. NAME OF HOSPITAL OR INSTITUTION (If not in bosquid), give street oddress University 901 Arcola Ave. d STREET ADDRESS e IS RESIDENCE ON A FARM? physician and campletely fulled Nursing Home, Wheaton. NO X 705 Chillum Road NAME OF First Middle 4 DATE Month corban Year DECEASED OF DEATH Bartlett Samuel Squires 19 67 6 (Type or print) S SEX 7. MARRIED X B. DATE OF BIRTH IF UNDER 1 YEAR LIF LINDER 24 HRS. 6 COLOR OR RACE 9. AGE (in years **NEVER MARRIED** last birthday) 9/11/1891 male WIDOWED | DIVORCED Caus. 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT please during most of working life, even if retired) INDUSTRY COUNTRY? post office employee Shiloh N.C. Government **HSA** 13. FATHER'S NAME ar removal. William S. Bartlett Elizabeth Squires 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT Address 226-48-0998 A 1B. CAUSE OF DEATH (Enter only one cause per tine for (o), (b), and (c).) transit PART I DEATH WAS CAUSED BY signed by 1 burial trans IMMEDIATE CAUSE (o) DUE TO Candit ans, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? USe NO X ğ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Caunty) (State) Not While factory, street, affice bldg., etc.) of work 21. I certify that (I) (this-hospital) attended the deceased fram... , and that death occurred at 2/40 M. from couses and on the date stated above. saw the deceased alive an 220. SIGNATIFRE ATTENDING PHYS director, page 3 shauld be filed v DIRECTOR M.D. 22c. PHYSICIAN'S Page 4 may NAME (Type) 23o. BURIAL CREMATION 23h DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) REMOVAL (Specify)
Burial Washington, Rock Creek Cemetery 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 250 RECD BY REGISTRAR VR A15 (4) 20 M 1/66 The S. H. Hines Company washington, DC



1	ı	MARYLAND STATE D  Division of STATISTICAL RESEARCH AND RECORDS, 30	EPARIMENT OF HEALTH 01 W. PRESTON STREET, BALTIMORE, MARY	/LAND 21201	
		CERTIFICAT	E OF DEATH	39686	
after death he funeral ge 1 and 2 after death.		PLACE OF DEATH  O. COUNTY MARYLAND  MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institute on STATE New Jersy b (O)	UNTY	
W 15 15 10		b CITY OR TOWN (If outside corporate imits,  Bethesda corporate imits,  L3 Mos 29 day:			
led in 24 hours		DETHESDA NAVAL HOSPITAL	d. STREET ADDRESS 1320 Sayrs Ave.	e IS RESIDENCE ON A FARM? YES NO	
arbon Til	3	NAME OF First Middle BASILE (Type or print)	OF DEATH	714 39 69 19	
xecuted was a complete of move carbiny event, in	2.		B DATE OF BIRTH  25 July 1916  9. AGE (In years lost buildoy)  27 July 1916	Months Doys Hours Min	
icate be ex ysician and please rem of, and in an	10o dus	LSUAL OCCUPATION (Give kind of work done no most of working te, even if retired)  S. Air Force  10b. KIND OF BUSINESS OR INDUSTRY 11:tary	11 BIRTHPLACE (County & State, or foreign country)  NEW YORK N. Y.	12 CHIZEN OF WHAT COUNTRY 7U.S.	
ertifica physic hen ple noval, c	13.	FRANK BASILE	14 MOTHER'S MAIDEN NAME THERESA BRANCO		
he death certific attending phys permit. Then p	15. (Ye		omas Basile 162 Haddon Av		
quires that t physician. signed by the burial-transit		IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (t).)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  DUE TO  (b)  Stoting the underlying couse (o), stoting the underlying couse (c)	tartures	INTERVAL BETWEEN ONSET AND DEATH	
The la r attence be has b use as	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)				
PHYSICIAN: The law re he haspiral ar attending this certificate has been detached for use as the s Dept. of Health prior to	CERTIFICATION	206 ACCIDENT WAS UNDERLYING ☐ 206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter noture of injury in Port I or Part II of Item 1B.)		
IG PHY the ha er this c detack	MEDICAL	Hour o.m. p.m. 19 While Not While of work of work	LACE OF INJURY (Home, form, chory, street, office bldg., etc.)	(County) (State)	
TENDIN ined by OR: Afte ould be		21. I certify that (1) (this haspital) attended the deceased framsaw the deceased alive an 31 July 19 67, and the	at death accurred of 215P M, fram cause	s and an the date stated abave.	
OR AT OR AT DIRECTO			M.D. ATTENDING MED. STAFF PHYS. PHYS.	226. DATE SIGNED  1 Aug 1967	
PITAL FRAL E pog or, pog d be fill	,	22c PHYSICIAN'S NAME (Type) H.O. Defries	22d. ADDRESS Naval Hospital, Bethe		
TO HOSPITAL OR ATTENDING Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be a should be filed with the Stark	L	BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OF Harleigh, C	amden, N.J. Camden, N	lew Jersey	
VR A15 (4) 20 M 1/66		Toseph Bocco, Camden, New Jersey	250. REC'D BY REGISTRAR 25b DATE AUG 2 1987	registrar's signature filiances Judge	



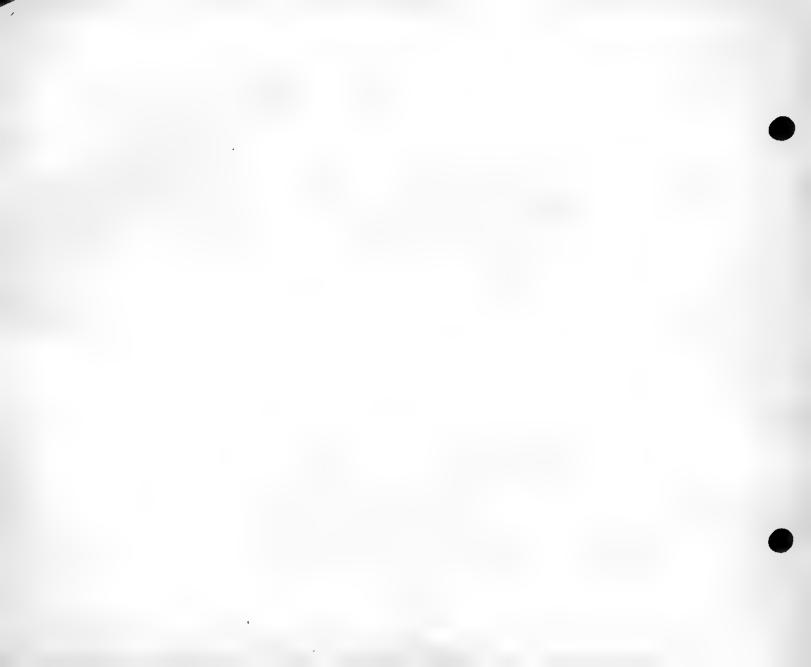
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18887 CERTIFICATE OF DEATH haurs after death funeral 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY o. STATE **b** COUNTY Montgomery MARYLAND Washington D.C. b CITY OR TOWN (f autside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 22 days Washington D.C. Takoma Park d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM within 72 1125 Spring Road Washington Sanitarium and Hospital YES NO 3 NAME OF 4 DATE 1ost Month Doy Year DECEASED and in any event, (Type or print) July 19 Car Becker DEATH Sarah (none) The law requires that the death certificate be executed cample NEVER MARRIED S SEX IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED remave last birthdoy) Months Doys Haurs WIDOWED DIVORCED 7-22-98 white pun 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 GT ZEN OF WHAT during most of working life, even if retired) please INDUSTRY **COUNTRY?** physician Laundry Worker
13. FATHER'S NAME U.S.A. Russia 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, attending phys Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO. 17. INFORMANT Address permit. Patient's chart INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line, for (b), opt (c).) burnal-transit PART I. DEATH WAS CAUSED BY ONSET AND DEAT IMMEDIATE CAUSE (a) signed by by the haspital ar attending physician. DUE TO Conditions, if ony, which gave rise to immediate cause (a). DUE TO stating the underlying cause last. has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1161 19 WAS AUTOPSY PERFORMED? NO certificate ā 20o. ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CITCAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20c TIME OF INJURY Month, Doy, Year (Etv or town) (County) (State) Hour p.m. factory, street, office bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased fram Page 4 may be retained DIRECTOR: and that death accurred at A M, fram causes and an the date stated above saw the deceased alive-on 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF M.D PHYS PHYS directar, page 3 shauld be filed 22c PHYSICIAN S 22d ADDRESS O HOSPITAL FUNERAL NAME (Type) RING 23a BURIAL CREMATION. 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) 7-21-67 CHESED SHEL EMMES CEM. WASHINGTON 0 C FUNERAL DIRECTOR ADDRESS 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 39683 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) n. COUNTY MONTSOMER MARYLAND b CITY OR TOWN (If autside carporate limits write RURAL and give nearest town) C LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) -tos-RANGLES e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS SILVER NO.1 YES NAME OF tos FIRST 4 DATE Doy Year DECEASED OF DEATH 315 196 (Type or pnnt) IF LINDER 24 HRS SEX 6. COLOR OR RACE AGE fin veors 7. MARRIED lost birthdoy) Months Days Raurs CAUC WIDOWED 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done. during most of working life, even if retired) COUNTRY? DAKOTA MICE WI 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, cremotion, or removol, offending physpermit Then p BACK 17. INFORMANT SETT 16. SOCIAL SECURITY NO (If yes give war at dates of service) 09-03 Naughte INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I DEATH WAS CAUSED BY. signed by the burial-transit p ONSET AND DEATH Page 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if ony, which gave (b) rise to immediate couse (a), DUE TO stating the underlying couse should be deteched for use as the with the Stote Dept. of Heolth prior to 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter notuce of injury in Port I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (County) 20c. TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) of work TO FUNERAL DIRECTOR: After 30 that (I) (we) last 21 I certify that (1) (this haspital) attended the deceased fram and that death accurred at saw the deceased alive an M, frash causes and an the date stated above 22o SIGNATURE 22b. DATE SIGNED MED DIRECTOR M.D PHYS 22c PHYSICIAN'S ADDRESS O HOSPITAL NAME (Type) OF CEMETERY OR CREMATOR (Stote) BATE THEREO! (County) REC D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 250 VR A15 (III) 25M 1/67 DATE AUG

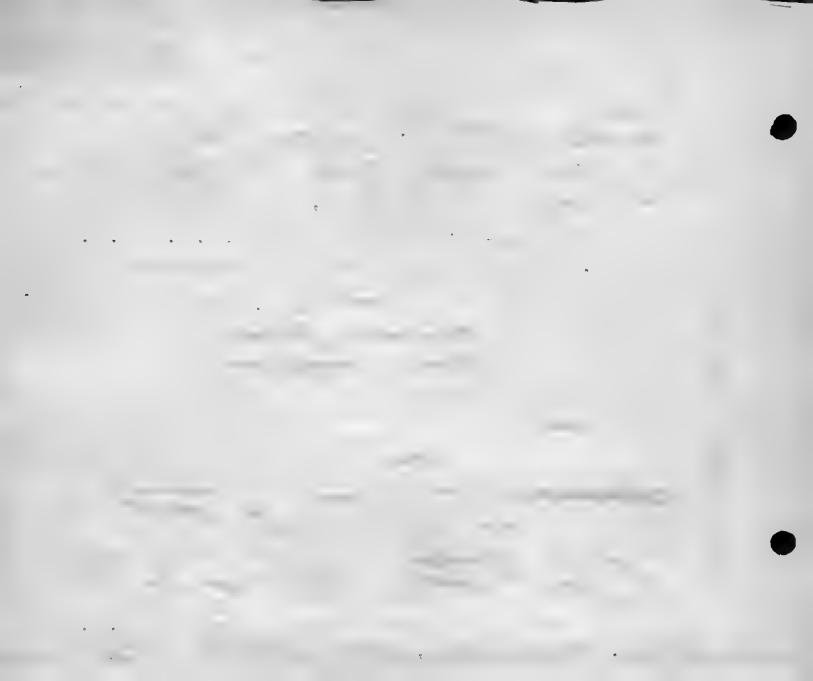


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY o STATE **b** COUNTY Page 무 b CITY OR TOWN (If autside carparale limits c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) pup write RURAL and give nearest town) IS RES DENCE ON A FARM? OF HOSPITAL OR INSTITUTION (If not in Respital, give street address) d STREET ADDRESS NO IL YES Item 18 Give Pages haurs after death with 3 NAME OF Middle DATE Month First Last Dov Year DECEASED OF (Type or print) OSZAZ DEATH Office alang S SEX AGE (In years IF JNDER IF LINDER 24 8 DATE OF BIRTH NEVER MARRIED b rthday) Months Days DIVORCED 10g JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT (State or fore an country) during most of working the, even if retired) COUNTRY? Examiner s 13 FATHER S MAM 14 MOTHER'S MAIDEN NAM SILVERSTONE pup INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO or remayal. (Yes, na, or unknown). If If yes give wor or dates of service) CHARLOTTE INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) This certificate shauld cremation, DUE TO Conditions, if any, which gave rise ta immediate cause (a). DUE TO stoting the underlying cause forwarded burnal WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 YES | 2 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of nivry in Part or Part II of Item 18.) agent, prior PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. 20c TIME OF M. JRY Month, Day, Year 20d IN. JRY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) Hour a m Nat While factory, street, office bldg , etc ) designated 21. I certify that I taak charge of the remains described above, held an Autapsy Inquiry X ρ Inspection X and in my apin on death resulted from Suicide funeral directar. Natural causes Hamicide Undetermined manner retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE may be re FUNERAL I Health or **EXAMINER'S** Addibss (Street Lity Town) or rounty) the t 23c NAME OF CEMETERY OR 23b. DATE THEREOF PUR AL CREMATION (State) 0 VR A 15ME 15

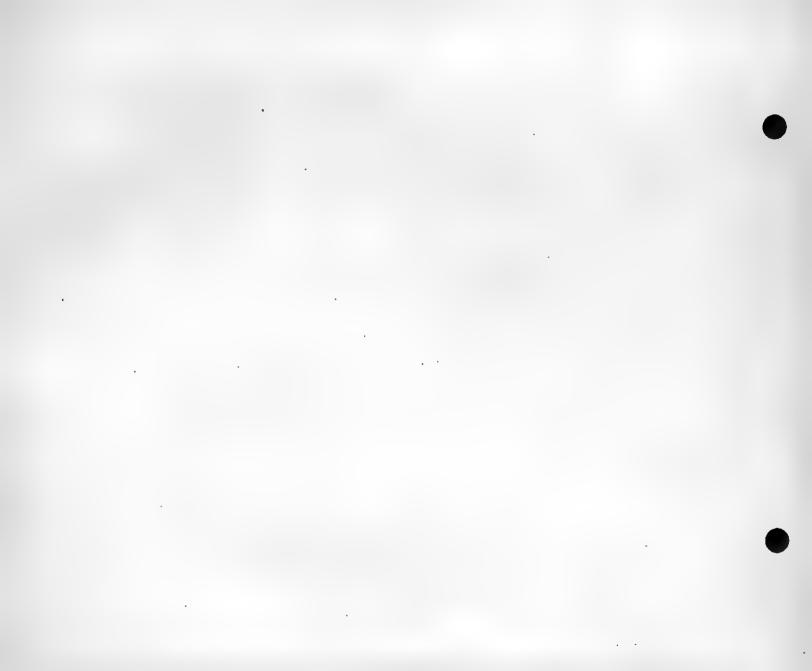


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY 0211 MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest fown) PILLESUS d. NAME OF HOSPITAL OF INSTITUTION (if not in hospital, Kenilworth Ave. ON A FARM? YES NO 203 3. NAME OF Middle DATE Month DECEASED (Type or print) DEATH 19 IF UNDER 24 HRS. 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lest birthday) Months Hours May WIDOWED [ DIVORCED T 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Washington. D. Insurance-Comptroller-Gov't-Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Elizabeth Clements William B. Berlin AddresSame 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT as Item (Yes, no, or unkown) (Ifyesa vewerordetesofservice) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (e), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION G VEN IN PART 1(b), 19. WAS AUTOPSY PERFORMED? NO X 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) 20s. ACCIDENT WAS UNDERLYING I OR CONTRIBUTING [ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d, INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) Month, Day, Year factory, street, office bldg., etc.) al work 19.65 to .... 19....., that (1) (we) last 21. I certify that (i) (this hospital) attended the deceased from....... 22br DATE 200. SIGNATURE SIGNED ATTENDING DIRECTOR MD. ADDRESS 22c 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) REMOVAL (Specify) 0.0 Rock Creek Cemefery Washington 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) PUMPHREY, Bethesda, Maryland 15M 9/60

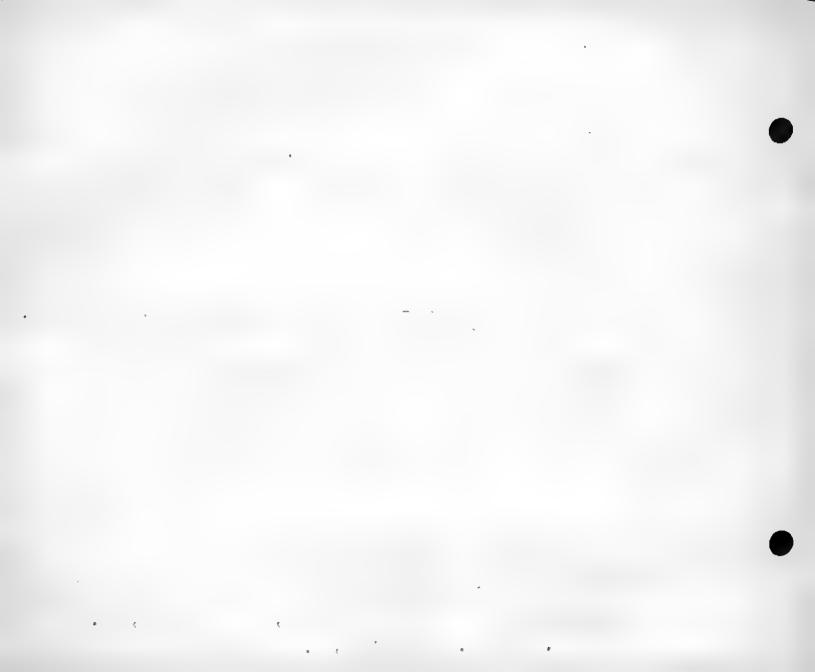
DEPARTMENT OF HEALTH



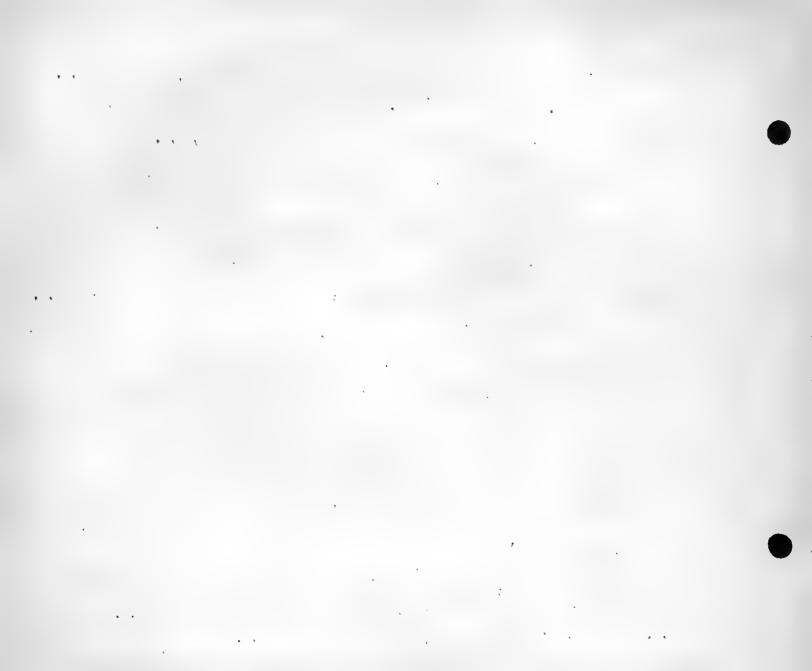
MARYLAND STATE DEPARTMENT OF HEALTH IVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY a. STATE **b.** COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give hearest town) Page c. LENGTH OF STAY IN 1b c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 24 hours Ξ papers. filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? in Amy, event, within 72 6505 ursing NO V YES within etely carbon NAME OF DECEASED 3. Middle DATE Month Last Day Year 0F remove carl SUBER (Type or print) DEATH 6 19 executed 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGR (th year) I IF UNDER 1 YEAR IIF UNDER 24 HRS 7. MARRIED NEVER MARRIED Months Davs Hours WIDOWED DIVORCED [ physician in please ri wal, and in 1Ba. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12, CITIZEN OF WHA þe INDUSTRY COUNTRY? Same 5.1 death certificate 13. FATHER NAME MOTHER'S MAIDEN NAME removal ling pt Then ed by the attendin transit permit. TI cremation, or ren 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address 17. (Yes, on, or unkown) | (If yes give war or dates of service)  $\mathcal{W}$ .  $\mathcal{W}$ CAUSE OF DEATH [Enter only one cause burial-transit burial, cremat INTERVAL BETWEEN The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. signed IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which реел gave rise to immediate the r undeterm **DUE TO** (a), stating the prior t underlying cause last. 33 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health certificate PERFORMED? Nunc the hospital or YES NO 4 PHYSICIAN: 2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 1) of Item 18.) detached this CAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, ) 2Df. (City or town) (County) (State) be de State factory, street, office bldg., etc.) MEDI After Id be d Not While While at work at work retained DIRECTOR: A age 3 should led with the 5 21. I certify that (I) (this hospital) attended the deceased from that (!) (we) last and that death occurred at 35 saw the deceased alive on \_M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED Se se page Mullar ATTENDING MED. STAFF Page 4 may 1 M.D. PHYS. DIRECTOR PHYS FUNERAL 22c. PHYSICIAN'S ADDRESS 22d. director, p NAME (Type) 20011 direct NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State REMOVAL (Specify) 0 FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25a. VR A15 (4) 2DM 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived | finstitution | Residence before admission) . o. COUNTY n. STATE **b.** COUNTY D CTY OR TOWN (If utside corporate I mits, write RURAL and give nearest town) MARYLAND Howard C LENGTH OF STAY IN 1b CITY OR TOWN (If guitside corporate limits, write RURAL and give negrest town) gug DOA Rural Simpsonville Olney e IS RES DENCI d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS Stote De NO V YES 🗔 in pencil in Item 18 Give Pages Montgomery General 3 NAME OF 4 DATE Day Year DECEASED
(Type or print) OF Boardlev DEATH Lewis Roval / MARRED TX S SEX IF UNDER IF UNDER 24 HRS 6. COLOR OR RACE B DATE OF BURTH 9 AGE (In years NEVER MARR ED ost birthdov) Months Dovs Hours in ony event within 72 hours after death. WIDOWED | D VORCED 11/15/89 96 Male Negro 11 BIRTHPLACE (State or foreign country) Oo USUAL OCCUPATION (Give kind of work done 2 CITIZEN OF WHAT 10b KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? INDUSTRY Gardener Landscaping please execute the certificate, writing the word "pending" in pencil in director. Pone 4 should be farwarded to the Chief Medical Examiners. Ilaryland
14 MOTHER'S MAIDEN NAME TI.S A 13. FATHER S NAME This certificate should be executed within Bell Boardley unknown IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dotes of service) 220-30-3415 Medical Records of Monte. General Hospit no INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter on y one couse per lipe for (o), (b), PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) H201 DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BLI NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) NO 200 EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH cremotion, 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg , etc.) O FUNERAL DIRECTOR: Poge Health prior to buriol, cremo ot work of work 21. I certify that I took charge of the remains described above, held an Autapsy Inspection V and in my apinian Natural causes . Accident Undefermined manner death resulted from Suicide Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Acerd & Kine Catal AND Or county) 23d LOCATION (City of Town) 23c NAME CELEMETERY OR CREMATORY Hopkins Church. Highland, Md. 250 REC D BY REGISTRAR 25b REGISTRAR'S SIGNATURE Robert L. Snowden. VR A15ME (5) Rockville, Md. DANUL 2 1967 6M 1/67



-	1	MARYLAND STATE DEPARTMENT OF HEALTH  OUVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND	
		೦೯೮೪೪ CERTIFICATE OF DEATH	
	funeral death.	1. PLACE OF DEATH Mont comery a. COUNTY  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admiss a. STATE b. COUNTY	sion)
	after the tes 1 after	b. CITY OR TOWN (if outside corporate limits,   c. LENCTH OF STAY IN 1b   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest to	wn)
	N DEST	write RURAL and give nearest town)	
	filled in papers. Fill 72 hour	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDE ON A FARM ON A FARM VESTINA	VI.7
	within pletely farbon parbon p	3. NAME DF First Middle Last 1.4. DATE Month Day Year	
	completely five carbon p	DECEASED (Type or print)  JANCES  Brooksie  DF DEATH JULY 8 196  5. SEX   6. COLOR OR RACE   7. MARRIED   7. NEVER MARRIED   8. DATE OF BIRTH   9. ACE (In years   IF UNDER 14 EAR)   F UNDER 24	UDE.
	and com		lin.
	be ex	10a. USUAL OCCUPATION (Cive kind of work done   10b. KIND OF BUSINESS OR during most of working life, even if retired)   10b. KIND OF BUSINESS OR   11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT COUNTRY?	
	icate be e physician n please r val, and in	HOUSEWIFE HEME BROALCREEK MD U.S.A.  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME	
	certifica iding ph Then remova	JAMES R Edelen Mary Rober MD  15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address	
	requires that the death certificate ding physician. been signed by the attending physithe burial-transit permit. Then ple r to burial, cremation, or removal, and the burial cremation or removal, and the second of the control of the	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 577.07.89840 Mr. 2 firthur Brooksic 5821 14th St. N.w.	
	the de n. by the nsit pe ematio	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).1	EN TH
	that tician.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASSEMBLE (1) ASSEMBLE (2) ASSEMBLE (2)  3 31X	7
	ires t phys phys sign buria buria	Conditions, If any, which gave rise to Immediate (b) Conclusal Otherwall	
	The law requires that or attending physician are has been signed buse as the burial-translath prior to burial, cre	cause (a), stating the underlying cause last. DUE TO Consection Heart Failure 5 do	40
	SICIAN: The law requospital or attending certificate has beconsidered for use as the pt. of Health prior to	F PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19. WAS AUTOP	
		PERFORMET YES NO  20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  BY CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	M
	HYSICIAN: he hospital this certific etached fol Dept. of H		
	Pet this Pet The Pet T	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, lam. While not While at work at wo	e)
	Sta at a sta	p.m. 19 (at work ) at work )  21. I certify that (I) (this hosofital) attended the deceased from Lips 30, 1962 to Jeely 2, 1967, that (I) (we)	las
	ATTENDI retained CTOR: A Should vith the	saw the deceased alive on 1967, and that death occurred at 46 M, from the causes and on the date stated ab	ove
	y be of both by	M.D. ATTENDING DIRECTOR DIRECT	
_	TO HOSPITAL OR ATTEND Page 4 may be retained TO FUNERAL DIRECTOR. A director, page 3 should should be filed with the	22c. PHYSICIAN'S NAME (Type) PAIL & JOHOS MD Seever Ligaries Two	
	Page Page FUN Girect Should	23a. BURIAL CREMATION, 23b. DATE MEREOF 23c. NAME OF CEMÉTERY OR CREMATORY 23d. (COCATION (City, town or county) (State)	)
	= = ·	24, FUNERAL DIRECTOR ADDRESS 250. REC'D BY RECISTRAR'S SICNATURE	
	VR A15 (4)	M. I she Teman - DATE . JUL 12 1967 frances from	1
	20M 1/65		

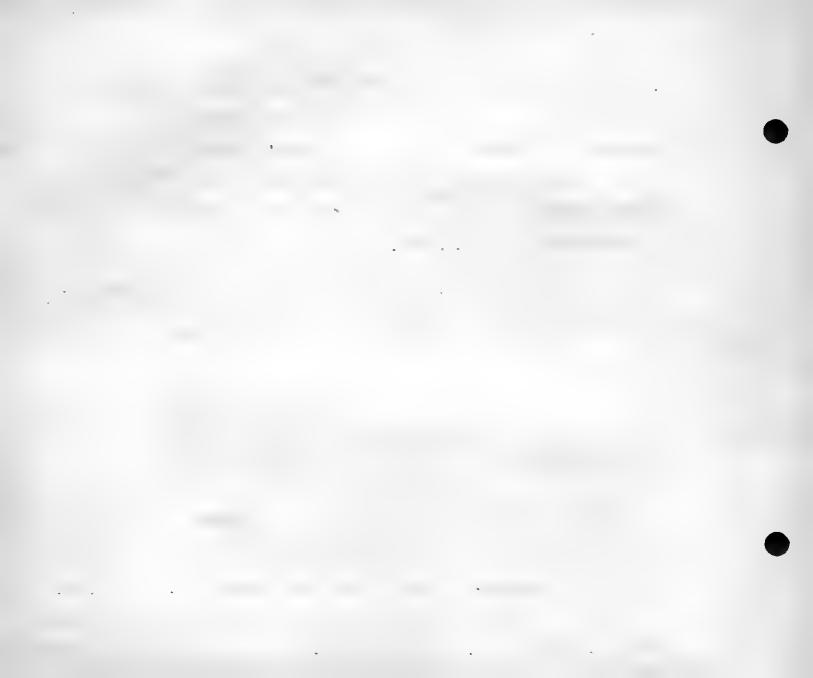


		1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND		
		101.1	CERTIFICATE OF DEATH		
	eath	野り			
	after death	er fe	1. PLACE OF GEATH  a. COUNTY  Montgomery  Marylano  2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)  p. COUNTY  Maryland  Maryland  Montgomery		
	afte	by the 1 Pages 1 urs after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
	hours	Page Pours	Silver Spring Thrs Silver Spring		
	24 h		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?		
	E 2	是豐人	Holy Cross Hospital 1810 Arcola Avenue YES NO NO		
1	within	n and completely in remove carbon in any event, within the carbon in the carbon in any event, within the carbon in any event, which is a carbon in any event, which is a carbon in a carbon in a carbon in a carbon in a carbo	3. NAME OF First Middle Last 4. OATE Month Oay Year OCEASEO (Type or print) Eva Sarah Brown DEATH July 19 19 67		
	ed	comple ve carl event,			
	executed	and compo	last birthday) Months Days Hours Min.		
		E e e	18a, USUAL OCCUPATION (Give kind of work done   10b, KIND OF BUSINESS OR   11 BIRTHPLACE (County & State, or foreign country)   12 CITIZEN OF WHAT		
	e D	sici,	during most of working life, even if retired) INOUSTRY Housewife Own home Washington. D. C. U.S.A.		
	Ilcat	yal, yal,	13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME		
	ert.	ding The ceme	Charles Hulien Minnie Lerch		
	돢	the attending physician a it permit. Then please re pation, or removal, and in a company of the	15. WAS DECEASED EVER IN U.S. ARMEO FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)  220-50-6788 May Chalma Handson Cl810 Hycola Avenue		
	dea	peri tlom	The 1220-50-0700 11743. Meeting woodgon Silver Spring. Md.		
	that the death certificate be sician.	200 = /	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH		
	law requires that tatter	signed by irial-transi urial, crem	TIMMEDIATE CAUSE (a) TO COLOR OF THE TO COLOR		
	res 1	burial burial	conditions, if any, which   (1) ( MARINE CARRED WASHERD - 24Cars		
	ingi	has been as the b prior to b	gave rise to immediate cause (a), stating the DUE TO ST Con Color		
	rw F	has been as the prior to	underlying cause last. (c)		
	The Iz or at	alth alth	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED?  YES NO IN		
		0 - 0			
	SICIAN: hospital		20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF GEATH		
	HYSI he h	L'esti	3 20c. TIME OF INJURY Month, Day, Year   2Dd. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (State)		
	5 to 10		Hour a.m.  While Not While factory, street, office bidg., etc.)  p.m. 19 at work at work		
	등교	- T 1	21. I certify that (I) (this hospital), Atended the deceased from the 190 to 11 hely, 19-1, that (I) (Ne) last		
	ATTENDI retained	St. Short	saw the deceased alive on		
	De J	S was	222. SIGNATURE / LE HALLO M.D. ATTENOING MEO. STAFF 22b. DATE SIGNED July 19, 1967		
	PITAL	Page filed	22c. PHYSICIAN'S \ \ 22d. AOORESS		
	SPIT 4 I		NAME (Type) Robert C. Haile, M. D. 8209 Kerry Road, Chevy Chase, Maryland		
	HOS Page	三音音( 1)	23a. BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)		
	Ħ	2	Burial July 22, 1967 Rock Creek Cometery Washington D C		
	1.00	ALE (A)	Pohopungal Direction of Charles of the Sthomes 8434 Georgia Avenue 250. REGISTRAR'S SIGNATURE		
		AI5 (4) 1/65	Warner E. Pumphrey, Inc. Silver Spring, Md. OATE OL 24 1961 (Charles yunge		

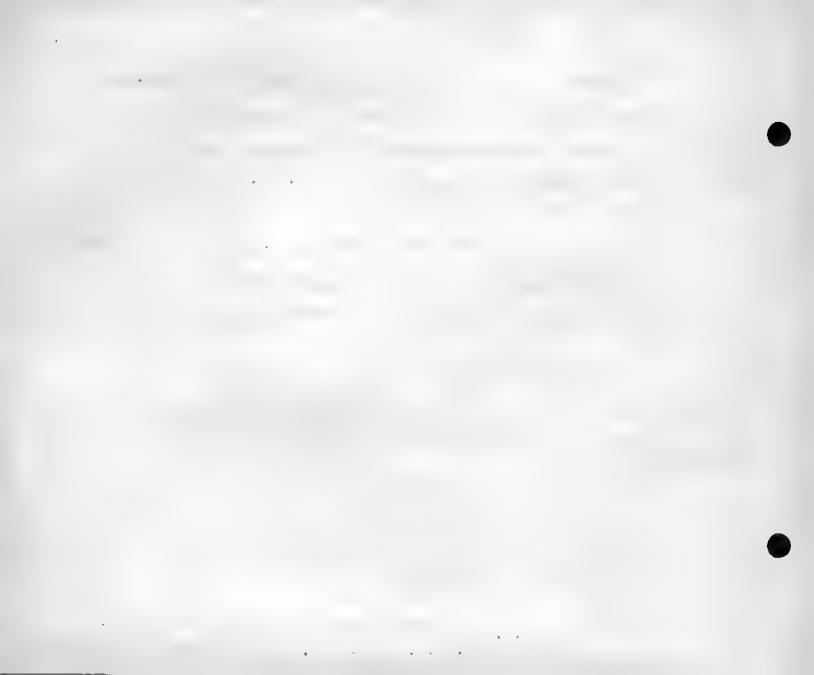


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 33650 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased leved, if institution: Residence before admission) COUNTY a. STATE MARYLAND the DWN (f outside conforate limits, URAL and give nearest town) CLENGTH OF STAY IN 16 CCITY OR TOWN (If outside corporate limits, write RURAL and live filled in by the papers. Pagi NAME OF HOSPITAL OR INSTITUTION (If, not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 13601 NO POC completely f NAME OF Middle DATE Month Yeor DECEASED Marshall Type or print) and in anywevent, DEATH 19 F UNDER ! YEAR NEVER MARRIED DATE OF BIRTH 9. AGE (Ipe IF UNDER 24 HR igst bifthdoy) Months Dovs Hours WIDOWED DIVORCED physician and one one of the please remé 1Do USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Retired Analyst 2COUNTRY? 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME or removal, IS. WAS DECEASED EVER IN U.S. ARMED FORCES?

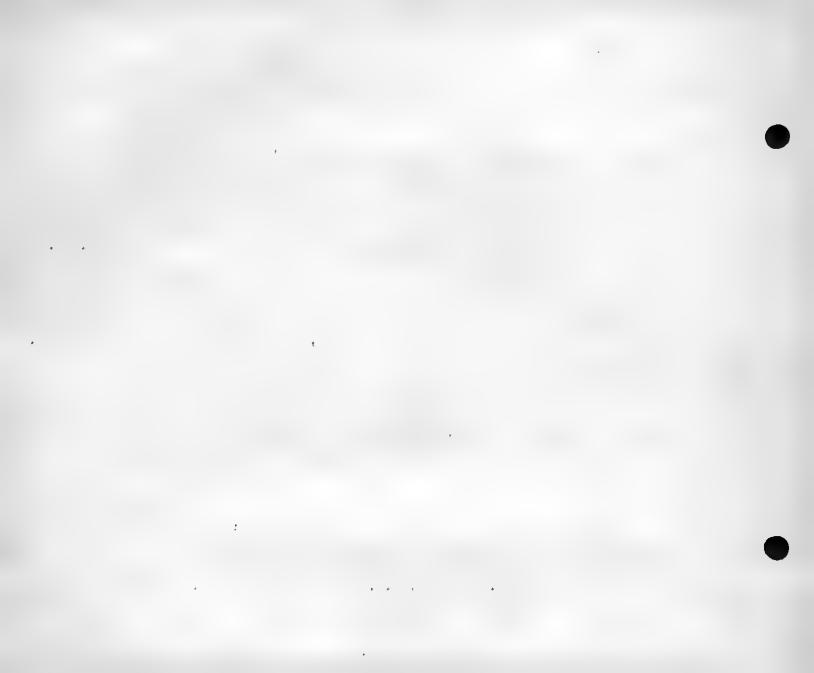
(Yes, no, or unknown) (If yes give war or dates of service) 17. INFORMANT 18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) May have been seen for (b). INTERVAL BETWEEN signed by the burial-transit p burial, cremati DINGE AND DEATH DUE TO Conditions, if ony, which gove ) (b) rise to immediate couse (a), DUE TO stoting the underlying couse this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? use far use Health YES X NO 2Do ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) detached OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc TiME OF INJURY Month, Dov. Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.) (City or town) (County) (Stote) WED Hour o.m. Not While ot work of work 21. I certify that (1) (mis hospital) attended the deceased from 1967, that (1) (see) last 1827, and that death accurred at 1675M, fram causes and an the date stated above. DIRECTOR: saw the deceased alive an 220 SIGNANURE 22b. DATE SIGNED STAFF PHYS. M.D. DIRECTOR directar, page shauld be filed 22c. PHYSICAN S 22d. ADDRESS TO FUNERAL NAME (Type) Horace W. Bernton 4743 Bradley Blud 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION, 23h DATE THEREOF 23d LOCATION (City or Town) (State) REMOVAL (Specify) National Memorial Park 1967 k Galls Church
RECD BY REGISTRAS
255 REGIST
1967 Georgia Avenue VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09691 CERTIFICATE OF DEATH requires that the death certificate be executed withing 34 liburs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission PLACE OF DEATH Maryland b COUNTY Montgomery o. COUNTY Montgomery MARYLAND c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)
Takoma Park 31 days Takoma Park B IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS physician and campletely felled en please remaye corban name YES NO IN Washington Sanitarium and Hospital 7667 Maple Aveune and in any event, within Middle DATE Month Yeor NAME OF First Lost DECEASED 7-21-67 Bruen, Sr. James Alton 19 DEATH (Type or print) IF LINDER 1 YEAR IF UNDER 24 HRS. S SEX B. DATE OF BIRTH AGE (in years 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** lost birthday) Months Doys Hours 7-11-04 WIDOWED DIVORCED white Male 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working . te, even if refined a Fleming & Co. New York America Stock Broker the attending physici nsit permit. Then ple mation, ar remaval, a 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Grace Revnolds Edward Bruen Address 17 INFORMANT 15 WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service Patient's Chart signed by the after burial-transit permi burial, cremation, a 579-01-9162 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per, upe for (o), (b), ONSET AND DEATH PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) attending physician DUE TO Conditions, if any, which gave nse to immediate couse (a). DHE TO stating the underlying cause **DIRECTOR:** After this certificate has been the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) detached far use e Dept. of Health NO Page 4 may be retained by the haspital ar TO FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 206 ACK DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER directar, page 3 should be detache shauld be filed with the State Dept. (City or fown) (County) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f 20c. TIME OF INJURY Month, Doy, Year Hour o.m. Not While factory, street, office bldg., etc.) at work pe . 1967, that (i) I well last 21. 1 certify that ((1) Athis hospital) attended the deceased from 6 - 26 7-21 196 / to 1967, and that death accurred at 61,25 AM, from causes and on the date stated above saw the deceased alive an 220 SIGNATURE ATTENDING PHYS DIRECTOR M.D. PHYS. 22d ADDRESS, 22¢ PHYSTCIAN S NAME (Type) NAME OF CEMETERY OR CREMATOR'S 23d LOCATION (Enty or Town) 230 BUR AL CREMATION (County) 23b DATE THEREO! REMOVAL (Specify) Rock reak emetery Washington 256 REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Hines Company VR A15 (4) 1967 2901 luth "t. N.W. Wash. L.C. 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03897 09692 CERTIFICATE OF DEATH death. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death funeral pup PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) n. COUNTY o. STATE h COUNTY HOWARD MONTGOMERY MARYLAND by This Pages b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If gutside carparate limits, write RURAs and give nearest town) papers. Pag hin 72 house ELLICOTT CITY OLNEY 13 DAYS e IS RESIDENCE ON A FARM? .⊑ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled i RT#2, TRIDELPHIA ROAD MONTGOMERY GENERAL HOSPITAL YES NO NAME OF Middle 4 DATE Month First Last Day Year and campletely DECEASED 1967 GEORGE ANDER BURGESS JULY 27 (Type or print) DEATH even IF UNDER 1 YEAR IF UNDER 24 HRS 8 DATE OF BIRTH AGE (In years SEX 6. COLOR OR RACE 7, MARRIED Y **NEVER MARRIED** MALE lost birthdoy) 64 yrs. Months NEGRO gus ( 11/1/02 WIDOWED DIVORCED 10o USUAL OCCUPATION (G vs kind of work done 10b KIND OF BUSINESS OR 13 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY MARYLAND FARMER 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME ar removal, MARY JANE BARNES FRANK BURGESS 1S WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) MEDICAL RECORDS 18 CAUSE OF DEATH (Enter on y one cause per line fox (a), (b), and (c)) PART I DEATH WAS CAUSED BY CORONARY THROMBOSIS, INSTANTANEOUS IMMEDIATE CAUSE (o). DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the hospital ar attending as the ficate has been Health priar to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X YES | LEFT CEREBRAL THROMBOSIS WITH RIGHT HEMIPLEGIA-13 DAYS DURATION fa 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter notize of injury in Port I or Port II of Item 18) detached f te Dept. af I **DIRECTOR:** After this certif (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form) (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Hour o.m. foctory, street, office bldg., etc.) OR ATTENDING of work ot work 21. I certify that (I) (this haspital) attended the deceased from 7/4/1962 19 . 19\_\_\_\_, that (I) (we) last . ta 19 67, and that death accurred at 9:30AM, from causes and on the date stated above saw the deceased alive an JULY 27 220. SIGNATURE 22b. DATE SIGNED · beharder JULY 27, 1967 DIRECTOR PHYS 22d. ADDRESS 22c PHYSICIAN'S TO FUNERAL NAME (Type) CHARLES S. WHITAKER, M.D. ELLICOTT CITY, MARYLAND directar, shauld b 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 230. BURIAL, CREMATION, BR OWNS CHAPEL CEMETERY DAYTON, HOWARD, MD. 7/30/67 2So, REC'D BY REGISTRAR 2Sb REG STRAR S SIGNATURE VR A15 (4) Charles DATE AUG 4 1987 ROCKVILLE. MD.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09893 CERTIFICATE OF DEATH **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law regures that the death certificate be executed within 24 haurs after death. funerāl PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) o. COUNTY o. STATE Maryland b. COUNTY Montgomery lontgomery MARYLAND in by the b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Brookeville IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS filled Lontgomery General ospital. YES NO NAME OF Middle First Inst 4 DATE Month carban Day Year 1067 DECEASED Burroughs OF July George Albert (Type ar pant) DEATH 9 AGE (In years IE UNDER 24 HRS S SFX 6 COLOR OR RACE 7 MARRIED 4 8 DATE OF BIRTH IF UNDER YFAR **NEVER MARRIED** b rthday) Manths Days 12-17-89 Hours White any WIDOWED DIVORCED Male 10a USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) TOP KIND OF BUSINESS OR and in 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT INDUSTRY Retired physician c COUNTRY? USA Haryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME remaval, George E.Burroughs Barbara Peters attending p 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, ar unknown) (If yes give wor or dates of service) en. Hospital Medical Records Montgomery 212-10-3922 DO 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEAT PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave (b) rise to immediate cause (a). DUE TO stating the underlying cause as the this certificate has been 19 WAS AUTOPS) PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? detached far use e Dept. af Health NO K 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20a. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER' MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) factory, street, office blda, etc.) Not While Page 4 may be retained by t TO FUNERAL DIRECTOR: After at wark 21. I certify that (1) (this hospital) attended the deceased from Leb-22, 1967, that (1) (we) los 1960 1967, and that death accurred at 6:30am, from causes and an the date stated above saw the deceased alive an\_ 220. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. page e filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Dr.A.D.Bonifant director, p shauld be 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BUR AL, CREMATION, (County) (State) REMOVAL (Specify) 7-24-67 Sunshine, Md Mt. Carmel 250 REC'D BY REGISTRAR H. Barber Funeral Home Cliares VR A15 (4) DATE JUL 25 25M 1/67 Laytons ville. Md.



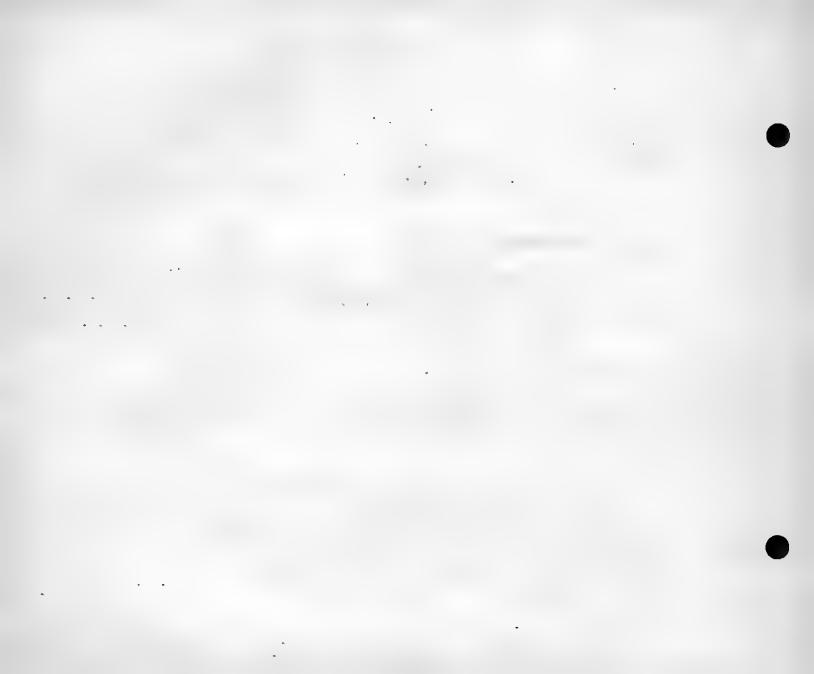
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09899 CERTIFICATE OF DEATH and death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH MARYLAND a. COUNTY b. COUNTY MARYLAND MONTGOMERY

C CITY OR TOWN IN outside corporate limits, write RURAL and give nearest town MONTGOMERY MARYLAND burial-fransit permit. Then please remave carban papers. Pages 1 burial, crematian, ar remaval, and in any event, within 72 haurs after b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) t LENGTH OF STAY IN 16 LAYTONSVILLE 3 DAVS BETHESDA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS PHYSICIAN: The law requires that the death certificate be executed within 24 YES NO K 3. NAME OF Middle 4. DATE Day Year DECEASED July (Type or pnnt) BUTLER 1967 DEATH IANE IF UNDER I YEAR IF UNDER 24 HRS B. DATE OF BIRTH AGE ( n years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths lest birthday) Days WIDOWED DIVORCED MINE 26, 1903 NEGRO 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 C TIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done COUNTRY ? during most of working life, even if retired) INDUSTRY MARYLAND

14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME EBECCA TS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates at service BERNICE VACKSON 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Carcinoma ovary with intra-abdominal spread, IMMEDIATE CAUSE (a) diffuse. DUE TO Conditions, if any, which gove use to immediate cause (a), DUE TO stating the underlying couse this certificate has been 19 WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES TX NO I 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 ar Part 11 af item 18) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PEACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Nat White at work L at wark Jacky 18, 1967, that the (we) las 21 I certify that (4) (this haspital) attended the deceased fram . 19 cely 18 1967, and that death accurred at 3 2 M, from causes and an the date stated abave saw the deceased alive an 22b DATE-SIGNED 22g SIGNATURE ATTENDING DIRECTOR MLD PHYS. 22d ADDRESS 22c, PHYSICIAN'S CAMAR. MID NAME (Type) 23d LOCATION (City or Town) (County) 23b. DATE THEREOF 23th BURIAL, CREMATION, SEMOVAL (Specify) Emory Grove Grove. E.MOEY 250 REC'D BY REGISTRAR FUNERAL DIRECTOR DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09695 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY a. STATE **b** COUNTY MARYLAND C LENGTH OF STAY IN 16 b (ITY OR TOWN (If outside corporate limits c. CITY OR TOWN (If autside carparate limits, write RURA, and give nearest town) ⊆ OR INSTITUTION (If not in haspital, give street address) IS RESIDEN ON A FARM NO Year DECEASED (Type or print) DEATH AGE (in years last birthday) 7. MARRIED NEVER MARRIED remove Months Days Haurs and in ony WIDOWED DIVORCED gud KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 C TIZEN OF WHAT please INDUSTRY COUNTRY? 14 MOTHER'S MAIDEN NAME cremotion, ar removal, SOCIAL SECURITY NO INFORMANT permit. or unknown) If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)-PART 1. DEATH WAS CAUSED BY buriol-transit IMMEDIATE CAUSE (o) by the hospital or attending physicion. DUE TO Canditions, if any, which gave rise to immediate cause (a), **DUE TO** stofing the underlying couse the So OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED THE TERMINAL DISEASE CONDITION NO 20d ACCIDENT WAS UNDERLYING LY 20b. DESCRIBE HOW INJURY OCCURRED. (Enter Sature of injury in Part i or Part II of item 18 OR CONTRIBUTING CAUSE OF DEATH etached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) Hour o.m. factory, street, office bldg, etc.) at wark 2]. I certify that (1) (this haspital) attended the deceased from ITI/24 10 7, ta JUG 22, 1967, that (1) (we) last be retoined 221967. saw the deceased alive an\_ and that death occurred My My fram causes and an the date stated above. 22g SIGNATURE 22b DATE SIGNED director, poy-M.D PHYS Poge 4 may b 22d ADDRESS 22r. PHYSICIAN S O FUNERAL University Rlud. NAME (Type) Kenneth Cruze 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCAT ON (City on Town) **BURIAL, CREMATION** (State) REMOVAL (Specify) VR A15 (4) 25M 1/67 wenter



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09696 09701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. I. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE. Mary Land b COUNTY Montgomery Montgomery MARYLAND delay m ts write RURAL and give nearest town) c LENGTH OF STAY IN 1b ~ Bethesda. d STREET ADDRESS 9602 Bulls RUD PK. NO V please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages I director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with far State This certificate should be executed within 24 hours after death 3 NAME OF DATE Day OF DEATH DECEASED Cora. 5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED X 8 DATE OF BIRTH 9 AGE ( n years last birthday) Months DIVORCED in ony event within 72 haurs after death WIDOWED 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR during most of working life, even if retired)
Student Washington.D 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Eillern- Bryson. 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, na, ar unknown) (If yes give war or dates of service None 1B CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Strangulation IMMEDIATE CAUSE (a) DUE TO 3 min Hanging Conditions flany, which gave t rise ta immediate cause (a), DUE TO stating the underlying couse Health priar ta burial, cremation, ar remayal, and 19 WAS AUTOPSY PERFORMED? PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part L or Part L of tem 3 shauld PR MARY I or CONTRIBUTING 
CAUSE OF DEATH (County) 20c T ME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) While at wark Ot work may be retained far yaur FUNERAL DIRECTOR: Page Bethesda Inspection X 21 | certify that I took charge of the remains described above, he d an Autapsy []. Inquiry X Natural causes . Accident . Suicide X. Ham cide death resulted fram Undetermined manner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY DEPUTY MED CAL EXAM NER JOHN G. BALL Address (Street, city, town, or county) Bethesda, Md. NAME 'Type) 23c NAME OF LEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL (REMATION 50 REMOVAL (Specify)
Cremation Cedar Hill Crematory
ADDRESS 25g REC D BY REG Suitland, Maryland 7-26-67 2Sa REC D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15ME (5) 13 A. PUMPHREY, Bethesda, Maryland DATEJUL 28 6M 1/67



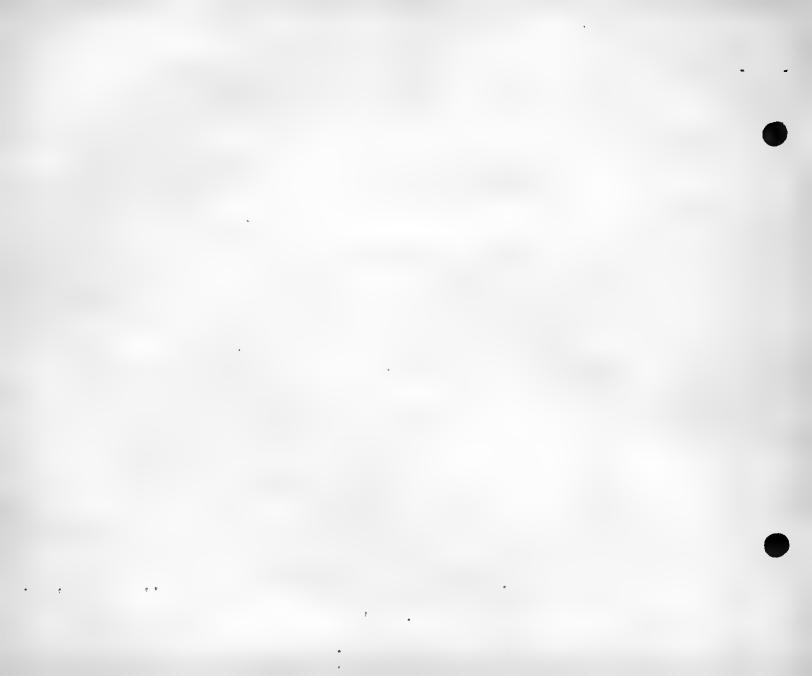
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09702 09897 CERTIFICATE OF DEATH filled in by the funeral in papers. Pages 1 and 2 within 72 hours after death. death. requires that the death certificate be executed within 24 hours after death puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY b COUNTY Montgomery o. STATE Montgomery Maryland MARYLAND b (ITY OR TOWN (If autside corparate imits, write RURAL and give nearest tawn) C. LENGTH OF STAY IN 15 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) Olney davs Gaithersburg d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RES DENCE ON A FARM? Montgomery General Hospital Park Avenue YES NO TO 3 NAME OF Middle First Lost 4 DATE Manth Day Year DECEASED Dolly Campbell July 19 67 signed by the attending physician and complete burial-transit permit. Then please remark-trant burial, crematian, or removal, and in any event, (Type or print) DEATH S SEX IF UNDER 1 YEAR I IF UNDER 24 HRS. 6 COLOR OR RACE B. DATE OF BIRTH 9 AGE (in years 7. MARRIED NEVER MARRIED last burthday) Months Days Hours WIDOWED DIVORCED female Negro 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME unknoun unknown IS. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) (If yes give war or dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address Montgomery General Hospital records unknown ulanosm INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) ONSET AND DEATH PART I, DEATH WAS CAUSED BY Oxem1a IMMEDIATE CAUSE (o) DUE TO Testinal Obstruction Conditions, if any, which gave rise ta immediate cause (a), DUE TO for use os the t f Realth prior to b stating the underlying cause certificate has been otdenocoru noma WAS ALTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 20a ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INBURY OCCURRED 20e. PLACE OF INJRY (Home, form, (City or town) (County) (State) O FUNERAL DIRECTOR: After this 20c. TIME OF INJURY Month, Day, Year Hour To.m. While at work factory, street, affice blda., etc.) OR ATTENDING 21. I certify that (1) (this haspital) attended the aftersed fram. Page 4 may be retained M. from causes and on the date stated above saw the deceased alive an and that death 22a SIGNATURE 22b DAJESIGNED DIRECTOR M.D 22c PHYS CIAN S 22d ADDRESS pe NAME (Type) Charles H. Ligan, M.D. Sandy Spring, Md. director, Should by 23a BURIAL, CREMATION 23b DATE THEREOF R3c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 7/11.67 LINCOLN PARK ROCKVILLE. MONTG. MD. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 2So REC'D BY REGISTRAR VR A15 (4) ROCKVILLE, MD. DATE



1/1/	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
FOR STATE	09693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	18703			
HEALTH DEPT.  □ ♣♣ ७ €	1. PLACE OF DEATH  a. COUNTY  MARYLAND  2 USUAL RESIDENCE (Where/deceosed lived if institution in the country b. COUNTY b. COUNTY b. COUNTY b. COUNTY	Residence before odpus von			
Post of the state	b CITY OR TOWN (If autside corporate I mits, write RURA write RUBAL and give regest fown)	and give nearest-town)			
1 1 2 2 1	d NAME OF HOSP TAL OR INSTITLT ON (If not a prospital give street address)  d STREET ADDRESS  3048 - Nauming	B IS RESIDENCE ON A FARM? YES NO TO			
85E N/	3 NAME OF DECEASED STATE OF MIDDEN OF OF OF MORNING OF	Doy Yeor			
after death 18. Give Pag alang with with the Sta	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 1013   9 AGE (In years lost buthday)	FONDER ) YEAR   IF UNDER 24 HR: Vanths Doys Hours Min			
4 haurs Hem 18 Office of Tand 2 v	100 USLAI OCCUPATION (G ve kind at work of 1°cd during most of working, ie, even if work of 1°cd live of the live	12. CITIZEN OF WHAT			
I within 24 in pencil in Examiner's Exominer's File pages	13 FATHERS, NAME  13 FATHERS, NAME  14 MOTHERS MA, DEN NAME  15 FATHERS, NAME  16 FATHERS, NAME  17 MOTHERS MA, DEN NAME  17 MOTHERS MA, DEN NAME  18 FATHERS, NAME	Igi bjeat			
xecuted withdring" in permit Exor	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) It is given wor guideness of solvices of solvices and solvices of solvices	3917-18quit			
be executed "pending" in hief Medical E ansit permit. F or removal, a	18 CAUSE OF DEATH (Enter only gate cause per ne for (a), (b), and (c))	INTERVAL BETWEEN ONSET AND DEATH Instant			
	S'/GM DUE TO	Instant			
certificate shauld wr ting the ward arwarded ta the C used as a burial-tr burial, crematian,	stoting the underlying cause last. (c)				
This certificate shauld be executed cate, writing the ward "pending" in be farwarded to the Chief Medical be used as a burial-transit permit.	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH RLT NOT DELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1/61	19 WAS AUTOPSY PERFORMED?			
tifficat tifficat Id be uld be	200 EXTERNAL CAUSE WAS PRIMARY Edge CONTRIBUTING Describe How INJURY OCCURRED (Enter noture of in Jry in Port 1 or Part 11 of dem 18)  Drive can: then sty Start study by and the	YES DO NO E			
INE ce share files 3 share ant,	20c TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f (City or town) foctory, street affice oldgetc)	(County) (State)			
is and in the state of the stat	21. I certify that I taak charge of the remains described above, held an Autapsy . Inspection . Inquiri	and in my opinic			
please established	ACTUAL OP COR ROLL CHIEF MEDICAL EXAMINER	ner 22. DATE SIGNEI			
RA ar	SIGNATURE  EXAMINER'S NAME (Type)  ASSISTANT MEDICAL EXAMINER [1]  DEPUTY MEDICAL EXAMINER [2]  Address (Street, city, town, or county)	1. 1967			
TO DEP necesso the fun 5 may TO FUNE	230 CRASCAMITON 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (Gry or Town	(County) (State)			
VR A15ME (5)	24 FUNERAL DIRECTOR - ADDRESS - 250 REGISTRAR 250 REGISTRAR	TRARS SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08704 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY b. CITY OR TOWN (f outside corposote limits, write RURAL and give nearest lown) OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after MARYLAND ARULAND MONTGOMERY CLENGTH OF STAY IN Th c. CITY OR TOWN At autside corporate limits, write RURAL and give nearest town) ety filled in by the ban papers. Page , within 72 hours a KUCKUILLE d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? SUBURBAN 205 S. WASHINGTON NO X NAME OF pan 4. DATE Lost and campletely DECEASED DEATH July 6 COLOR OR RACE 9. AGE (In years IF JNDER 7 MARRIED 8. DATE OF BIRTH **NEVER MARRIED** Days Hours In any DIVORCED WIDOWED EMALE WHITE 10o USUAL OCCUPATION (Give kind of work done TOP KIND OF BUSINESS OR 13 B REHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** ROCKUILLE TELEPHONE OPERATO COURTHOUSE - RKuille or remaval, ACO B DDSON 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMAK (Yes, no, or unknown) lift yes give wor or dotes of service S. SpRiNA 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09700 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission requires that the death cerafficate be executed within 24 hours after deat o. COUNTY **b** COUNTY West Virginia Montgomery MARYLAND ve carbon papers. Pages 1 event, within 72 haurs after physician and campletely filled in by the t C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town)
Silver Spring Morgantown 5 days e IS RESIDENC ON A FARM: d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 912 Garrison Avenue Holy Cross Hospital 4 DATE 3 NAME OF Middle Lost Dov Year DECEASED Carrico July 13. 67 Hobart 19 (Type or print) DEATH B DATE OF BIRTH 9. AGE ( n years IF UNDER I YEAR IF LINDER 24 HRS S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months □April 3.1897 and in any WIDOWED DIVORCED White Male 11. BIRTHPLACE (County & State or foreign country) 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 100. USUAL OCCUPATION (Give kind of work done COUNTRY? U.S.A. Univer West Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME the ottending privs burial, cremation, ar remaval, Joseph Carrico Mary Britten 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes no or unknown) (If yes give war or dotes of service Lula Craig Carrico .Morgantown.W. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any which gove rise to immediate couse (a). DUE TO ificate has been s for use as the b f Health priar ta b stoting the underlying couse Page 4 may be retained by the haspital ar attending las! WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART LIA CERTIFICATION O FUNERAL DIRECTOR: After this certificate 20h DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury of/Port 1 or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour o.m factory, street, office bldg. etc.) ot work 21. I certify that (I) (this haspital) attended the deceased fram and that death accurred a 05 AM, fram causes and on the date stated abave saw the deceased alive an 22b. DATE SLENED 220 SIGNATURE STAFF PHYS M.D. DIRECTOR director, page shauld be filed 22c PHYSICIAN S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (Cittor Town) (County) 230. BURIAL, CREMATION, 23b DATE THEREOF BUREWAYAL (Specify) Maple Grove Cemetery Kingwood W. VA 1967 2Sb REGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH-DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived if institution Residence before admission) mark b. COUNTY MARYLAND montgomery TY OR TOWN (If cuts de corporate Vimits, c LENGTH OF STAY N 16 OR TOWN (If outside corporate imits, write RURAL and give nearest town) RJRAL and give negrest town / with the Stote Depart e IS RESIDENCE ON A FARM? d. NAME OF HOSP TAL OR INSTITUTION ( f not in hosp to, give street oddress) d STREET ADDRESS along with form 18 Give Poges YES NO Z 3 NAME OF Midd e DATE Year DECEASED 0F .Type or print) DEATH S SEX OR RACE 7 MARRIED DATE OF BIRTH 9 AGE (In years bistadoy) Months Davs Hours WIDOWED DIVORCED in any event within 72 hours ofter death certificate should be executed within 24 hours in pencil in Item 100 USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Carpenter D. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME rancis 16 SOCIAL SECURITY NO 17 INFORMANT Address the Chief Med col (Yes, no, or unknown) ( fiyes give war or dotes of service 18 CAUSE OF DEATH (Enter only one couse per https://doi.org/10.1000/10.1000/10.1000/10.1000/10.1000/10.1000 INTERVA. BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) writing the word DUF TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO 0 stoting the underlying couse puo last 19 WAS AUTOPS PERFORMED? remova! PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(O) 20 YES 200 EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH D DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Page should MEDICAL EXAMINER: MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, 20st TIME OF INJURY Month Day, Year While Not While At work please execute the cremot DIRECTOR: Page ot work 21 I certify that I taok charge of the remains described above, held an Autapsy Inspection 🔀 and in Natural causes death resulted from Accident Suic de X Homic de Undetermined manner be retoined CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER funerol may be re FUNERAL 1 Hea th prior SIGNATURE O DEPUTY DEPUTY MPOICAL EXAMINER NAME Type) or county the OF THETERY OR PREMATORY 230 BUR AL CREMATION 50 REMOVAL (Specify raper Cemetery 25b REGISTRAR S SIGNAT 250 REC D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1 167

MARYLAND STATE DEPARTMENT OF HEALTH

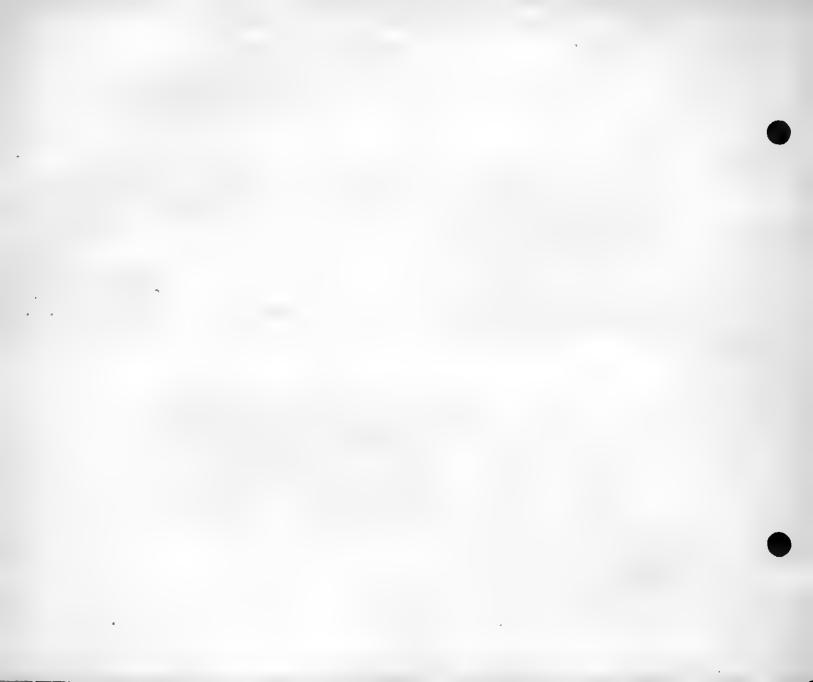


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VR A15 (4) 25M 1/67		W.W. CHAMBERS	SILVER SPRING M	DATE UL 14 1967	Charles Judge

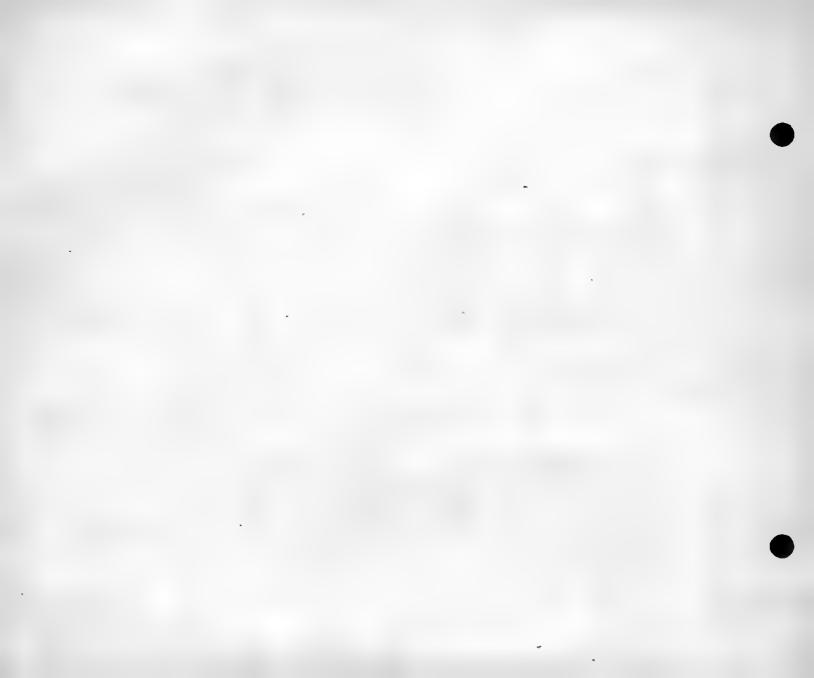


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09708 09703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY b COUNTY Poge MARYLAND C LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nearest town) 2, c. PM3. P Depdi d. NAME OF HOSPITA. OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRES icate, writing the word 'pending" in pencil in Item 18 Give Pages 1, be forwarded to the Chief Med.col Exominer's Office along with form ON A FARM? 6 St. Martins ND A This certificate should be executed within 24 hours ofter death NAME OF DATE OF DEATH DECEASED (Type or print) AGE (In years 7 MARRIED lost birthdoy) Months and in any event within 72 hours after death. WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) Homemaker 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME · Yuginia 17 INFORMAN 2H62 Ontario Rd. NW (Yes, no, or unknown) (If yes give wor or dotes of service No Miss Shirley Biddison Washington, D. No INTERVAL BETWEEN 18 CAJSE OF DEATH (Enter on y one couse per line for (o), (b), and (c)) PART I DEATH WAS CAUSED BY Bionchial IMMED ATE CAUSE (o) DUE TO Conditions, if any, which gove Scular rise to immediate couse (a), DUE TO stating the underlying couse Artano Sclerosis PART .I DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN NIPART 1(c) WAS AUTOPS removol PERFORMED? NO X 20o EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part II of item 18.) 3 should 4 should k PRIMARY I or CONTRIBUTING I CAUSE OF DEATH cremation. MEDICAL (City or town) (County) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Hour o.m. foctory, street, office bldg., etc.) of work Inspection (X), Inquiry (X), 21 I certify that I took charge of the remains described above, held on Autopsy and in my opinion death resulted from: Notural couses 1 Accident [ Suicide [ ]. Homicide [ Undetermined manner funeral director CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 23d LOCAT ON (City or Town) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION, 23b DATE THEREOF (County) 0 Baltimore, Md. Parkwood Cemetery 2Sb REGISTRAR'S SIGNATURE ECDBY REGISTRAR 1967 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1/67



the last	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
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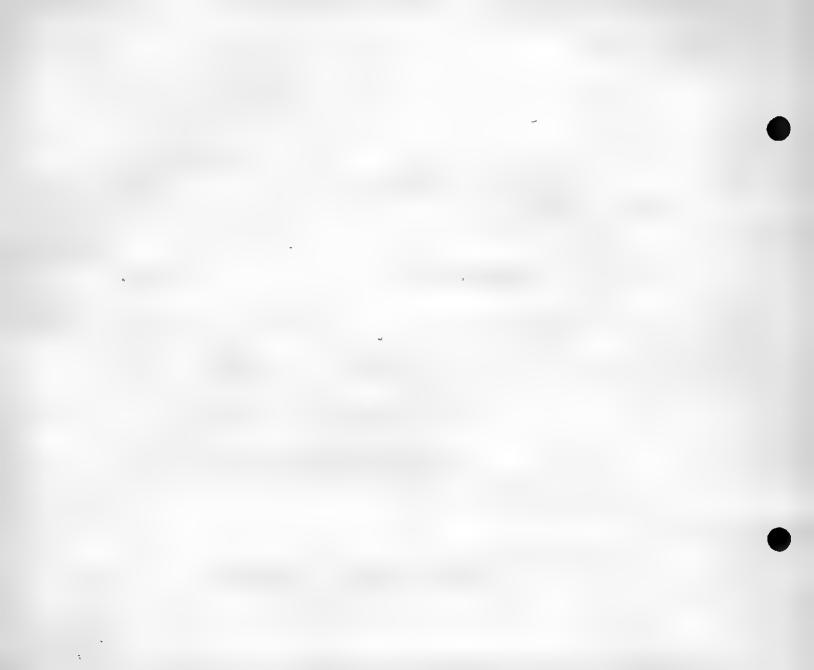
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 haurs after death puo PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY pletely filled in by the run. anmer MARYLAND b CITY OR TOWN (if outside corporate limits. CLENGTH OF STAY IN 16 CITY OR TOWN (If outside carparate limits, write RURA), and give areas write RURAL and give hourest lawn <0 YYYa d STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? NO X YES 3 NAME OF DATI Manth Doy Year campletely DECEASED 21 YOUR (Type or print) 196 DEATH 5 SEX 6 COLOR OR RACE AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED B. DATE OF BIRTH Last birthday) Months Days WIDOWED DIVORCED 100 JSUA: OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (County,& State, or fareign country) 12 CITIZEN OF WHAT COUNTRY ? dunga mast of work no life, even il/tetired) INDUSTRY no mp Housewill 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM buria, crematian, or remayal, attending phys 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na, or unknown) (If yes give war or dates of service) IB. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: signed by the burial-transit ONSEL AND DEATH IMMEDIATE CAUSE (a) 4 may be retained by the hospital or attending physician. DUE TO Canditions, if any, which gave nse ta immediate cause (o). DUF TO stating the underlying couse has been lasi PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED 70 THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PHYSICIAN: The PERFORMED? NO ficate Ē 20a ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part ) or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Hour a.m. lactary, street, affice bldg., etc.) While Not While at wark at work 1967 to 7-24 1967 that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased from 7-29 1967, and that death accorded at 875 P. M., from causes and on the date stated above. saw the deceased alive on 22a. S.GNATURE 226 DATE SIGNED director, page 3 should be filed v M.D PHYS PHYS 22d. ADDRESS PHYS CIANS FUNERAL NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23g BURIAL, EREMATION, 23b. DATE THEREOF 23d LOCATION (City or Town) (County) REMOVAL/Specify) Hyattsville, Pr. George. Mt. Lebanon Cemetery July 31,1967 2 Burial Donata M. Stein Hebrew Memorial ADDRES 2 Carroll St. 30 RECD BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 N.W. -Wash. , D. d. DATE AUG



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE b. COUNTY O d† FLORIDA CLENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ON (f not n besalto d STREET ADDRESS S RESIDENCE DN A FARMA 3051 CECELI YES ND 3 NAME OF DATE Lost Month Dov Year DECEASED File pages 1 and 2 with the COLE (Type or print) DEATH S. SEX 6 COLDR DR RACE 9 AGE (in years FUNDER I YEAR R DATE DE BIRTH 7 MARRIED lost pythdoy) Months Days Hours after death. WIDDWED DIVDRCED YES Examiner's Office 100 USUAL DCCUPATION (Give kind of work done 10b KIND OF BUSINESS DR 11 BIRTHPLACE (State or foreign country) 12 CIT ZEN DE WHAT during most of working life, even if retired) INDUSTRY FLORIDA 13 FATHER S NAME 14. MOTHER'S MA DEN NAME 72 hours ROBBINS IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO Medical (Yes, no, or unknown) (If yes give wor or dates of service) within GORDONW, COLE SAME AS AR IB. CAUSE OF DEATH (Enter only one couse per line, for (o), (b) and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY any event IMMEDIATE CAUSE (o) word DUE TO the Conditions, if any, which gove ! to. rise to immediate cause (a). DHE TO stating the underlying couse farwarded and WAS AUTOPSY PERFORMED? ar removal, PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) hauld be 20o. EXTERNAL CAUSE WAS 3 should PRIMARY Sor CONTRIBUTING CAUSE DE DEATH cremation, **EDICAL** 20c TIME DF INJURY Month, Doy, Year PLACE OF INJURY (Mome, form, (City or town) foctory street, office b dg , etc ) ,4 please execute of work of work 21 I certify that I took charge of the remains described above, held on Autopsy Inspect on Inquiry DIRECTOR: ond in my opinion deoth resulted from Natural causes Accident Hamic de Undefermined manner may be retained FUNERAL DIRECT CHIEF MEDICAL EXAMINER ACTITAL 22. DATE SIGNED SIGNATURE Health NAME (Type) 0 REC D BY REGISTRAR VR A15ME (5) 6M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09707 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived of institution: Residence before admission o. COUNTY o. STATE Maryland b. COUNTY Montgomery Montgomery MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) C LENGTH OF STAY IN 16 c CITY OR TOWN ( f guitside corporate limits, write RURAL and give negrest town) 3 WERKS Rockville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3709 Elby Street Route 1. Stony Creek Rd. YES NO DO NAME OF First Middle 4 DATE Manth Year DECEASED LEE HELEN CONNELLY July 18. 19 67 DEATH (Type or print) remave car IF UNDER 1 YEAR | IF UNDER 24 HRS S SEX 6. COLOR OR RACE B DATE OF BIRTH 9 AGE (In years 7. MARRIED NEVER MARRIED birthday) Manths White Aug. 7, 1898 Female WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during mast of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT INDUSTRY Maryland Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, Ollie Downes Julia Duley (Yes\_na, ar unknown) (If yes give war or dates at service) 16. SOCIAL SECURITY NO. 17. INFORMANT Daughter Address P. O. Box 405 218-24-3397 Mrs. Louise L. Richard- Glendale, Md. burial, cremation, INTERVAL BETWEEN TB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY signed by the burial-transit p ONSEL AND DEATH Pul. mitantance IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse as the last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART 1(g) WAS AUTOPSY PERFORMED? NO DE 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part It of dem 1B) 20g ACCIDENT WAS UNDERLYING [3] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20f (C+y or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) at work at work 19 54, to\_ \_, 19\_67, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram \_\_\_\_ Poge 4 may be retained 17/ 19 1. 2, and that death occurred at 3. J. AM, from causes and an the date stated above. saw the deceased alive an\_ FUNERAL DIRECTOR: 22b. DATE SIGNED 22a. SIGNATURE DIRECTOR PHYS. M D 22d ADDRESS 809 Veirs Mill 22c PHYSICIAN'S O HOSPITAL STEPHEN JONES NAME (Type) Rockville, Maryland 23d LOCATION (City of Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL CREMATION, (County) Burlal (Specify) 7-21-67 Darnestown Cemetery Darnestown, Maryland 256. REGISTRAR S. SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR PUMPHREY. Bethesda, Maryland VR A15 [4]

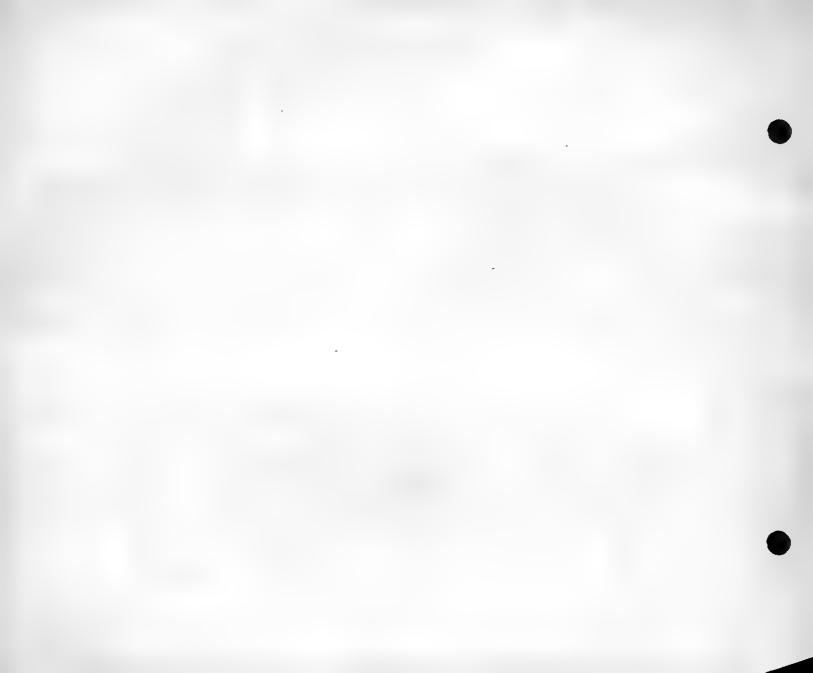
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 20700 HEALTH DEF PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) a. COUNTY please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to I director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with formin-PM3 Page Nentelonne c LENGTH OF STAY IN 15 guiside corporate limits, write RURAL and give negrest town) 3 kn. 10 mm 13.27/25dz. d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? Jones Mill Rd. 130.23 This certificate should be executed within 24 hours ofter death. If NAME OF 4 DATE DECEASED Cooper 19 6 (Type or pant) AGE (In years lost birthdoy)

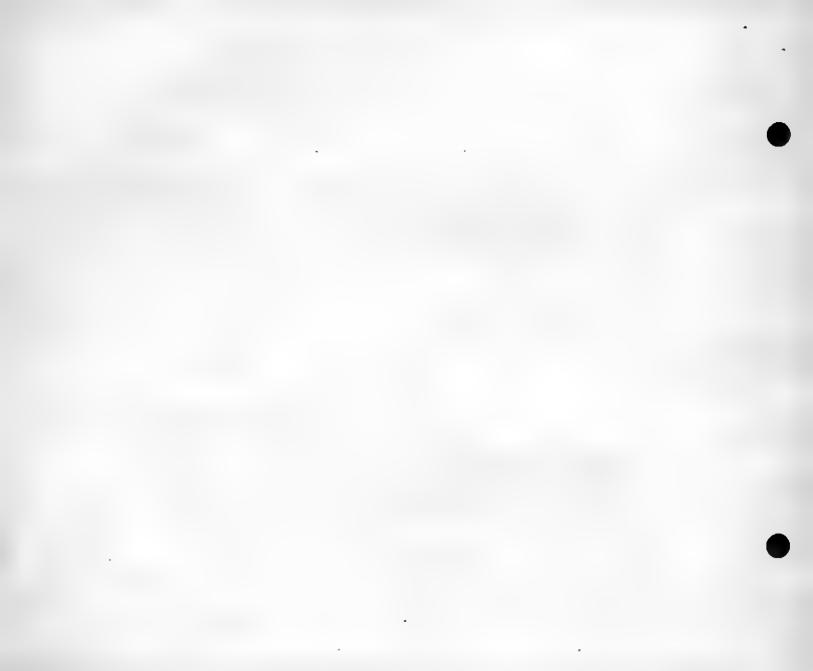
2 4 Yrs. S SEX 6 COLOR OR RACE 8 DATE OF BIRTH 7 MARRIED NEVER MARRIED Months July 9, 1443 Negroid. within 72 hours after death. 100 JSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** Maryland 13 FATHERS NAME 14 MOTHER'S MAIDEN NAME 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY AS CAUSED BY

IMMEDIATE (AUSE (0) ONSET AND DEATH cremation, or removal, and in any event I III I Conditions, if ony, which gove nse to immediate couse (a), DUE TO stoting the underlying couse be used os 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) FICATION YES 📧 NO 200 EXTERNAL CAUSE WAS PRIMARY DE OF CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW NURY OCCURRED. (Enter noture of nigry in Part L or Port II of item 18.) 3 should 1 20e PLACE OF NJURY Thome, form 20d INJURY OCCURRED 20f (City or town) (County) 20c TIME OF INJURY Month, Day, Year (State) foctory street office bldg, etc.) While of work Not While 5 may be retained for your O FUNERAL DIRECTOR: Page Health prior to buriol, cremain /Xontamora Md ot work 21. I certify that I taak charge of the remains described above, held an Autopsy 💢, Inspection K and in my apinian the funeral director. death resulted fram. Natural causes \_\_\_\_, Accident \_\_\_\_, Suicide \_\_\_\_, Hamicide 🗹, Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPLTY MED CAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type 23c NAME OF CEMETERY OR CREMATOR) 23b DATE THEREO! VR A15ME (5)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09709 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY Montgomery District of Columbia MARYLAND requires that the death certificate be executed within 24 hours after CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Bethesda Days Washington d STREET ADDRESS e IS RESIDENC ON A FARM d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014 4319 River Road N. W., Apt.1 YES NO X 3 NAME OF Middle 4. DATE Lost First DECEASED (Type or print) July Nicholas Stephen Cooper DEATH 19 IF UNDER I YEAR IF UNDER 24 HRS 9. AGE (In years S SEX 6 COLOR OR RACE 7. MARRIED X NEVER MARRIED last birthday) Months Haurs □ September 27,1921 WIDOWED DIVORCED s gned by the ottending physician and co bursol-transit permit. Then please rema burial, cremotion, or removol, and in any Male White 11. BIRTHPLACE (County & State, ar fareign country) 12 CITIZEN OF WHAT 100 LSUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR during most of working life, even if retired)
Assistant Supervisor COUNTRY? INDUSTRY USA Federal Government Pennsylvania 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME John Cooper Anna Mulich IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANTThe Medical Recordidress 16 SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give wor or dotes af service) Not available The Clinical Center, Bethesda, Md. 20014 Yes INTERVAL BETWEEN ONSET AND DEATH Unknown 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY Probable septicemia IMMEDIATE CAUSE (a) Page 4 moy be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by DUF TO Canditions, if any, which gave Candidiasis - gastrointestinal tract 2 weeks rise to immediate cause (o). DHE TO as the I stoting the underlying couse 2 months (a) Acute Myelogenous Leukemia WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES X NO F 20b DESCRIBE HOW INJURY OCCURRED (Enter notuce of injury in Port I ar Port II af item 1B.) 20g ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or fown) (County) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year Nat While foctory, street, affice bldg., etc.) of work 21. I certify that (X) (this haspital) attended the deceased fram June 16 , 1967, to July 21 , 1967, that (X) (we) last saw the deceased alive an July 21 19 67, and that death accurred at 4:45 M, from causes and an the date stated above 22b DATE SIGNED 22o SIGNATURE ATTENDING 1 22 July 1967 PHYS M.D. DIRECTOR 22d ADDRESS The Clinical Center, National 22c. PHYSICIAN NAME (Type) Institutes of Health, Bethesda, Maryland Thomas Clancy, M.D. 23d. LOCAT ON (City or Town) 23c NAME OF CEMETERY OR CREMATORY (County) 23b DATE THEREOF 230 BURIAL, CREMATION Burial Specify) St. Mary Magdalene Cem., Easton, Pennsylvania July 24,67 24. FUNERAL DIRECTOR BETHESDA, MD. ROBERT A. PUMPHREY DATE

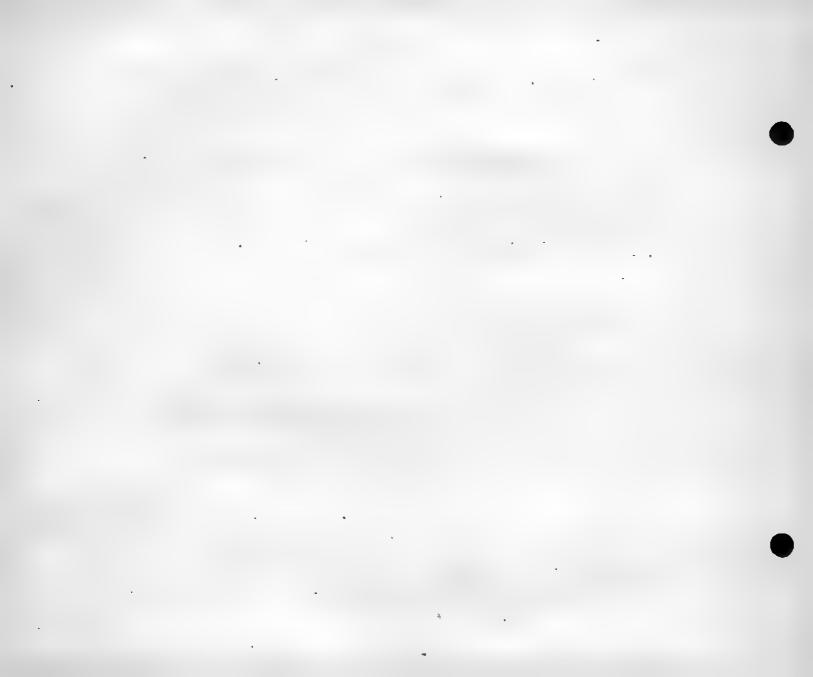


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 097:0 MEDICAL EXAMINER'S CERTIFICATE FOR STATE HEALTH DERT. 1 PLACE OF DEATH USUAL RESIDENCE (Where deceased led, if institution Residence before admission) a\_ COUNTY b. COUNTY\_ MARYLAND monlgomery delay Voutside corporate mit C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and write RURA, and P M3 e IS RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS arm a NO 4 in Item 18 Give Pages NAME OF DATE DECEASED OF DEATH ant d 1967 (Type or print) NEVER MARRIED 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS birthdoy) Months Doys DIVORCED any event within 72 hours after death Office . l and 2 100 USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) Own home Chief Medical Examiner's 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME This certificate should be executed within permit. File rier Alexy. S. S., Md. 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dotes of service "pending" None None INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line tory(o), (b), and fc).) PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) e, writing the ward farwarded to the Ch DUE TO Conditions, if any, which gove rise to immediate cause (a). E **DUE TO** stoting the underlying couse and lost used removal, 19 WAS AUTOPS) PERFORMED? PART 31 OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO pe 20a EXTERNAL CAUSE WAS 2Db DESCR BE HOW thours OCCURRED (Enter noture of nursy in Part 1 or Port 1 of term 18) 3 shauld 1 PRIMARY I or CONTRIBUTING I cremation, ar should EXAMINER: CAUSE OF DEATH files. MEDICAL 20c TIME OF NURY Month, Doy Year 20d NJURY OCCURRED 20e PLACE OF NJURY (Home form 2D( (City or town) (County) (Stote) Hour om foctory, street, office bidg , etc.) While Not While far your FUNERAL DIRECTOR: Page 19 of work ot work please execute 2) I certify that Litook charge of the remains described above, held on Autopsy Inspection and in my opinion Notural couses death resulted from: Suicide Undetermined monner funeral directar. Hom (ide retained CH EF MEDICAL EXAM NER ACTUAL 22. DATE SIGNED 5 may be ret TO FUNERAL D Hearth prior t SIGNATURE 23c NAME OF EMETERY OR CREMATOR) the BURIAL CREMATION Arlington Nat'l Cenetery Arlington, VR A15ME (5) 6M 1/67 Inc. lver Spring.

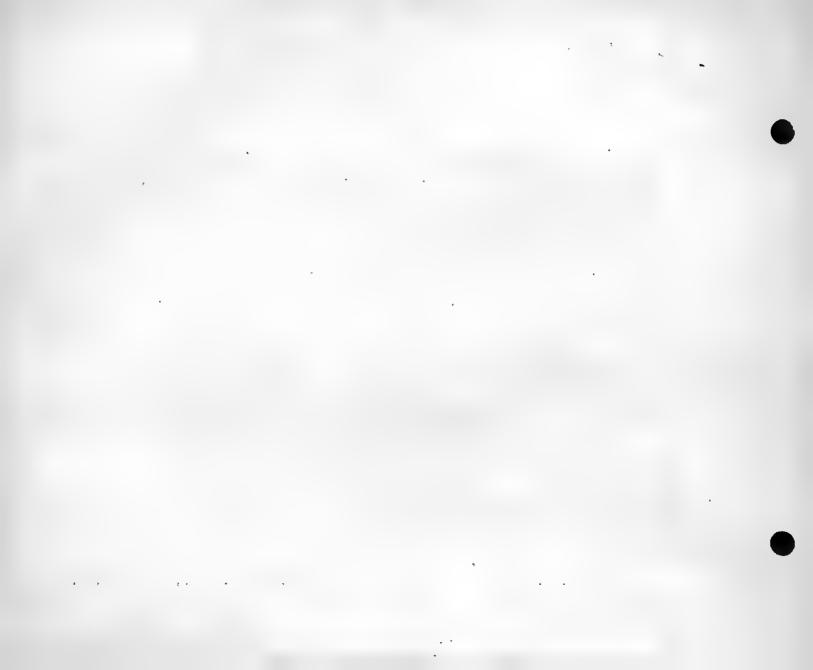
MARYLAND STATE DEPARTMENT OF HEALTH



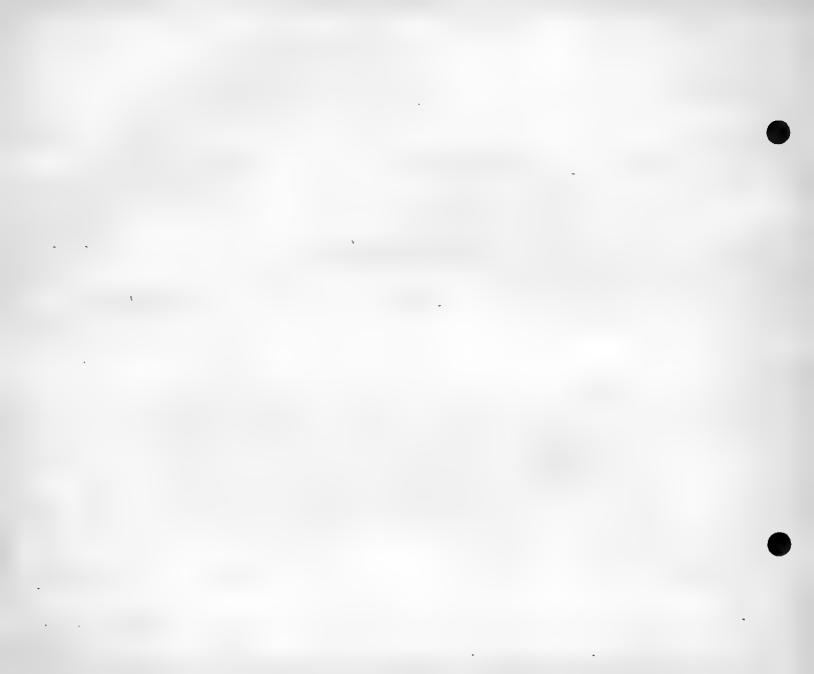
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 🙈 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) campletely filled in by the funeral PLACE OF DEATH O COUNTY PROPERTY o STATE Maryland **b** COUNTY Prince Georges Montoomery MARYLAND ( LENGTH OF STAY IN 1b c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) b. CITY OR TOWN (If autoide carparate limits, papers. Pagi hin 72 hours c write RURAL and give nearest tawn) Wheaton d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM Hyattsvit la NO X Universit∨N Nursino 2807 Nicholson St. Home Middle 4 DATE 3. NAME OF First Last Manth DECEASED OF Corbett Cob= James Frank 19 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED birthdoy Manths Days Haurs White Male WIDOWED DIVORCED and in any E E 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a, USJAL OCCUPATION (Give kind of work done INDUSTRY during most of working the even if retired to R attending physician sermit. Then please NY. Bronx 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME MEI 1. CORBETT JAMES INFORMANT Address CAME AS 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO ORBETT 578 10 6665A (Yes, no or unknown) (If yes give wor or dates of service) INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per one for (a) (b) and (c) burial-transit p ONSET AND DEATH PART ! DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave ase to immediate cause (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been as the last PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? NO. 205. DESCRIBE HOW IN URY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) TIME OF INJURY Month, Doy, Year factory, street, office bldg, etc.) Nat While at wark at wark 21. I certify that (I) (this hospital) attended the deceased fram. from causes and an the date stated above and that death accurred saw the deceased alive an 226 DATE SIGNED SIGNAPIRE 770 ATTENDING STAFF PHYS. DIRECTOR M.D 2YH9 22d. ADDRESS NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23g BURIAL CREMATION DATE THEREOF MARYLAND REMOVAL (Specify) ADENS BURG. LINCOLN CEM 2So REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 72 haurs after death PLACE OF DEATH 2 USBAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE a. Coun Montgomery **b** COUNTY MARYLAND Montgome rv c CITY OR TOWN (If outside corporate limits write RURAL and give necrest town) c. LENGTH OF STAY IN 1b b CITY OR TOWN (IF outside corporate I mits, hours att ROCK VIRAL and give nearest town) Rockville. e. IS RESIDENCE ON A FARM? d STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 24 paper 1643 E. Jefferson Street 1643 E. Jefferson Street YES 🗍 NO To event, within requires that the death certificate be executed within 4. DATE Month 3 NAME OF First Middle Year rsicion and completely please remove carban DECEASED OF DEATH July 20,1967 EDUTN Τ. CORNELIUS 19 (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 74 HRS DATE OF BIRTH 5. SEX 6 COLOR OR RACE NEVER MARRIED 7 MARRIED 8 (ast birthdoy) Male Hours White 5/24/87 WIDOWED cremation, or removal, and in any 12. CITIZEN OF WHAT 10g USUAL OCCJPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) COUNTRY? COUNTRY? during most of working life, even if retired) INDUSTRY attending physician sermit Then please Missouri 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Samuel Cornelius Delilah Lear 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war ar dates of service) permit 449-50-6236 Lottie R. Cornelius-Item# 2 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. signed by the burial-transit p ONSET AND DEATH GERNULOUTIC IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO as the priar tal stating the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far une Health NO 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detachild (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e PLACE OF INJURY (Hame form, 20f. (City or town) (County) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED factory, street, office blda., etc.) Hour a.m. While Nat While of work at work JUNE , 1963 , to 7-20, 1967, that (1) (we) last 21. 1 certify that (I) (this haspital) attended the deceased from\_\_\_\_ 2.0 1967, and that death accurred at 200 A.M. fram causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE MED DIRECTOR M.D PHYS PHYS. director, page 3 shauld be filed v 22c. PHYSICIAN'S W. Montg. Ave., Rockville, Md. W. G. Hall NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF 23a. BURIAL, CREMATION, REMOYAL (Specify) Burial 7/24/67 Rockville, Maryland Parklawn Funeral Home-1331 Rockville Pike Rockville, Md. 24 FUNERAL DIRECTOR VSD11 //100101 VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09713 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY MARYLAND b CITY OR TOWN (If autide corporate limits write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR-TOWN (If autside corporate smits, write RURAL and give negrest tawn) hour. K DYM A d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) e IS RESIDENCI and in any event, within 72 ON A FARM? NO E-NAME OF 4. DATE carbon Year DECEASED (Type or print) DEATH 6 COLOR OF RACE IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED AGE (In years lost hirthday) Months WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10g JSUAL OCCUPATION (Give kind of work done 11 BIRZEPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during 19051 of warking the, even if retired) Peoples Drug Store Crabity MOTHER'S MAIDEN NAME 13. FATHER S NAM saac Ublker buriol, crematian, or removal. Emmalune Murphree S DEGEASED EVER IN L. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMAN permit. (Yes no, or unknown) (If yes give war or dotes of service 415-12-2304 IB. CAUSE OF DEATH (Enter only one cause per fine for (a), (b) and (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSEL AND DEATH IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate cause (a). DUF TO stating the underlying couse etoched for use as the Dept. of Health prior to last WAS AUTOPS PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART ITO NO 20b DESCRIBE HOW INJURY OCCURRED (Enter notice of injury in Part or Part II of item 18) 20a ACCIDENT WAS UNDERLY NG OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Hame, farm 20f. (City or town) 20c TIME OF IN JRY Month, Day, Year 20d INSURY OCCURRED (County) (State) Hour o.m. factory, street, affice bldg., etc.) of work ot work 21. I certify that (1) (this hospital) attended the deceased fram 1967, that (1) (we) last saw the deceased alive an 17 1967, and that death accurred at 500 M, fram causes and an the date stated above. 22b DATE SIGNED 220. SIGNATURE 7-21-67. M D DIRECTOR PHYS director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) Seruch J. 927 Pershina Dr. Silver Spring 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BUR AL, CREMATION 23b DATE THEREOF (Stote) (County) REMOYAL (Specify) Pincoln Cometery Prince Georges



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after deat I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY Moruland Montgomeru b City OR TOWN (If outside carparate limits, c LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) 15 hrs filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES NO K With With NAME OF Day Year completely DECEASED Louise cressler Vulu (Type or print) DEATH 19 67 SEX 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS remave NEVER MARRIED last birthday) 12-25-1877 WIDOWED DIVORCED 10a, USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Own home Nebraska America 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayaj. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Mrs., Donald Staley, 1703 (Yes, no, ar unknown) (If yes give war ar dates of service 능 213-50 -491 Chart Washington 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: SALVER burial-transit IMMEDIATE CAUSE (a) signed by DUE TO burial, o Canditians, if any, which gave (b) rise ta immediate cause (a), DUE TO stating the underlying cause O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending as the priar tal last. 19 WAS AUTOPS)
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) has YES 🔀 NO 20a ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) 20c TIME OF INJURY Manth, Day, Year (County) (State) Hour a.m. factory, street, affice bldg., etc.) Nat While at wark 1903, ta 7 - 14, 1967; that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from approximately saw the deceased alive an 7 - 14 1967, and that geath occurred all PM, fram causes and on the date stated above. TO FUNERAL DIRECTOR: 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. 22c PHYSICIAN'S 22d ADDRESS NAME (Type) Seruch J. Kimble 927 Pershing Dr., Silver Spring, Md. 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) REMOVAL (Specify) Arlinaton National Cemetery Arlington. 256 REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Georgia Avenue 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Inc. Si Pumphrey.



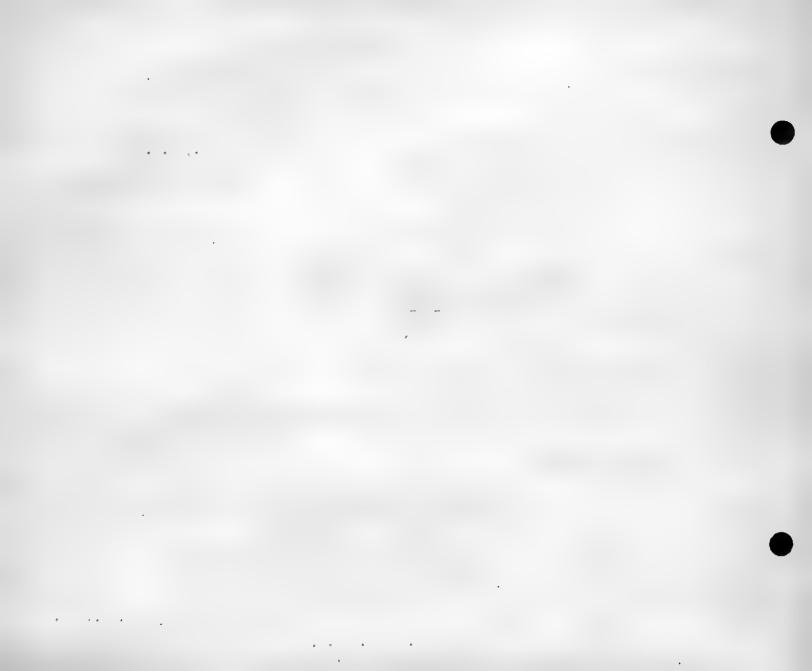
	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMO	ORE 1, MARYLAND
		0344,
1	1. PLACE OF DEATH  e. COUNTY  2. USUAL RESIDENCE (Where decessed lived b. CO	d, If institution: Residence before edm
-	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. C.TY OR TOWN (if susside corporate limits,	write RIRAL and give nearest town
	write RURAL end-gibre neerest town)	1/2
-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  d. STREET ADDRESS  d. STREET ADDRESS	e. IS RESID ON A F
	Juberban 305 M. Haamst	THAT I YES N
3	DECEASED	South Dey Yeer
-	5. SEX   6. COLOR OR RACE 7. MARRIED   NEVER MARRIED   B. DATE OF BIRTH   9. AGE (In y	ears   IF UNDER 1 YEAR   IF UNDER 24
1	Toa. USUAL OCCUPATION (Give kind of work , 10b, KIND OF BUSINESS OR INDUSTRY IT BIRTHPLACE (County & Stete, or joreign county	
	done during most of working life, even 'f retired'  . Mart / Zare	d U.J.
1	13. FATHER'S MAIDEN TAME	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? , 16. SOCIAL SECURITY NO. 17. INFORMANT	dress
	[Yes, no. Pupkown] (Ifyes give wer or detes of service)	1000
-	18. CAUSE OF DEATH (Enter only one cause per line for .e). (b), end (c).	INTERVAL BETW
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Neonatal atelectases	ONSET AND DE
	DUE TO O	12 hr
	Conditions, if eny, which geve rise to immediate cause	
	(e), steting the underlying DUE TO	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	GIVEN N PART I(e) 19. WAS AL
/   <del>}</del>	PART II. OTHER SIGNIF, CANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION	YES N
COTICE	206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED. (Enfer neture of injury in Pert I or Pert I of Item 18: OR CONTRIBUTING 2AUSE OF DEATH (I) (IF ETHER, NOTIFY MEDICAL EXAMINER)	1
		(County) (S
Ì	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, ferm. 20f. (City or town) Hour e.m. 19 Hour e.m. 19 et work et work	n .
	21. I certify that (I) (this hospital) attended the deceased from	3 3, 1907, that (1) (v
	saw the deceased alive on July 319.6.7, and that death occured at	
	220. SIGNATURE ATTENDING MED. STAFF	7/23/67
	22c. PHYSICIAN'S 22d. ADDRESS	1/00/0/
1	NAME (Type)	NINAMA A MATA
1 3	230. BURIAL CREMATION, 23b. DATE THEREOF LASE, NAME OF CEMETERY OR CREMATORY, 23d. LOCATION (CIT	- m. Jaskielica
	7/2467 Susawan Harrion Lerrosio	REGISTRAR'S SIGNATURE
The	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 256, REC'D BY REGISTRAR 256, DATE JUL 28 1967	ycharles Juan
1 1/3	The thir care Clarket House	0-0



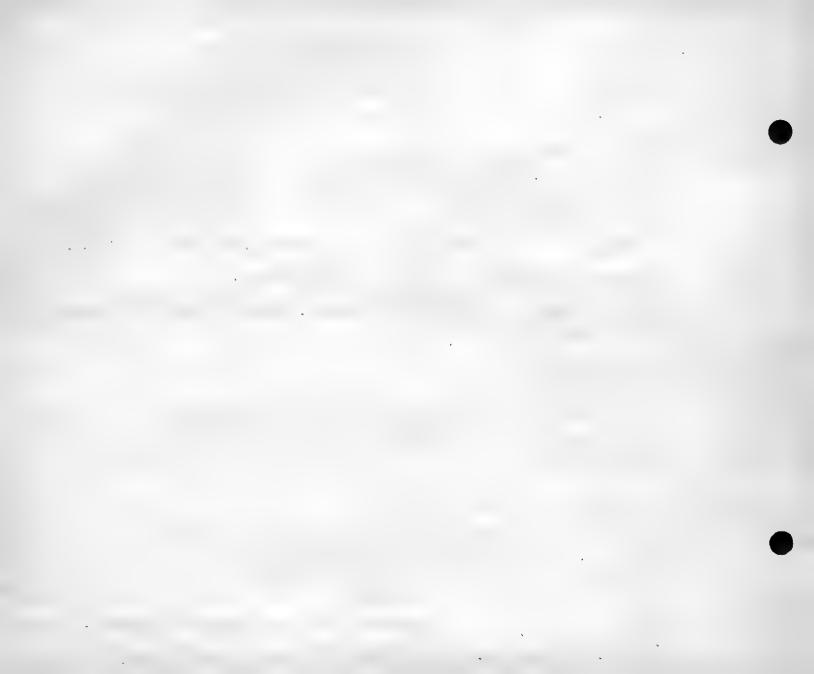
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00216 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH b COUNTY a. COUNTY o. STATE Montgomery District of Columbia MARYLAND signed by the attending physician and campletely filled in by the burial-transit permit. Then please remave carban papers Pages, burial, cremation, or removal, and in any, event, within 72 haurs att LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) 3 days Washington Wheaton e IS RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS University Nursino Home YES NO X 844 Jefferson St. N.W. Middle 4 DATE 3 NAME OF Last Doy Year DECEASED DEATH (Type or print) Walter Crockett Thomas IF UNDER 24 HRS. AGE (In veors IF UNDER 1 YEAR S SFX B DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthday) Manths Days Hours DIVORCED March 3. 1899 WIDOWED male colored 12 CIT ZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY South Carolina Handyman USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Crockett Louise Galmon 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dates of service) 17. INFORMANT Address 16. SOCIAL SECURITY NO 578-05-6276 No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY Adeno carcinema of cecum IMMEDIATE CAUSE (o). Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached for use as the burial-tran shauld be filed with the State Dept. af Health priar ta burial, are DUE TO Conditions, if ony, which gove and Transverse Colon rise ta immediate cause (a). DUE TO stating the underlying cause 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO -20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) 20o ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or fown) (County) (State) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Not While factory, street, affice bldg., etc.) at wark at work 21. I certify that (I) (this haspital) attended the deceased from July 25, 19 47, to July 27, 1967 that (I) (we) last saw the deceased glive an July 25, 1967, and that death accurred at 730AM, from causes and an the date stated above 220. SIGNATURE 22b DATE SIGNED STAFF PHYS. 7-28-67 shin M.D. 22d ADDRESS10820 Georgia Avenue 22c PHYSICIAN'S NAME (Type) Blanche G. Bendler Wheaton. Maryland 23d. LOCATION (City or Town) 23a BURIAL, (REMATION, REMOVAL (Specify) Burial 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (County) 8-1-67 P. G., Md. Harmony Memorial Park Landover 9 25b. REGISTRAR'S SIGNATURE 2Sq REC'D BY REGISTRAR FUNERAL DIRECTOR 621 Fla., Ave Williames 1967 VR A15 (4) Funeral Home Washington, D.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ed in by the funeral opers. Pages 1 and 2 n 72 hours after death requires that the deoth certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH Montgomery o. STATE b COUNTY Maruland MARYLAND Montgomeru CTY OR TOWN (If autside carparate limits c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and aive negrest town) write\_RLRAL and give nearest town) Jakoma Park ueats Park lakoma d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 616-Eln Street Elm Street 616 NO K YES 4 DATE Pour Pour NAME OF First Middle Lost Month Day Year DECEASED July 19 67 Maru Curtis DEATH (Type or print) S SEX DATE OF BURTH AGE (In years JF LINDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED **NEVER MARR ED** last birthday) Manths Days May 18, 1894 Haues White Female signed by the attending physician and co burial-transit permit. Then please remo-burial, cremotion, or removal, and in any DIVORCED WIDOWED 10a. USJAL OCCUPATION (Give xind of work done KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT 10b during most of working life, even if retired) INDUSTRY COUNTRY ? Own home Germantown. Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Wallace Hughes Martha Biggs 616 Elm Street WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT [Yes, na, ar unknown] (If yes give war ar dates of service) No Vone INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). **NSET AND DEATH** PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) by the haspital or attending physician. 4331 DUE TO Cardiovasco 61 Canditions, if any, which gave C15045/ rise to immediate cause (a). DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been be detoched for use as the State Dept. of Health prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) (State) Haur a.m. factory, street, affice bldg., etc.) OR ATTENDING at work at wark 21. I certify that (I) (this hospital)-attended the deceased fram\_ 19 le 7 that (I) (-we) last 19 6 3. to Page 4 may be retained b 19 L. J. and that death accurred at 9 M. fram causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 22a, SIGNATURE M.D. DIRECTOR PHYS **PHYS** , poge 3 be filed 22d ADDRESS 222 PHYSICIAN'S St nw 4830 Griswold NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (County) (State) 23a. BURIAL, CREMATION, REMOVAL (Specify) Darnestown Presbuterian Cemeteru Burial Darnestown 2Sq REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

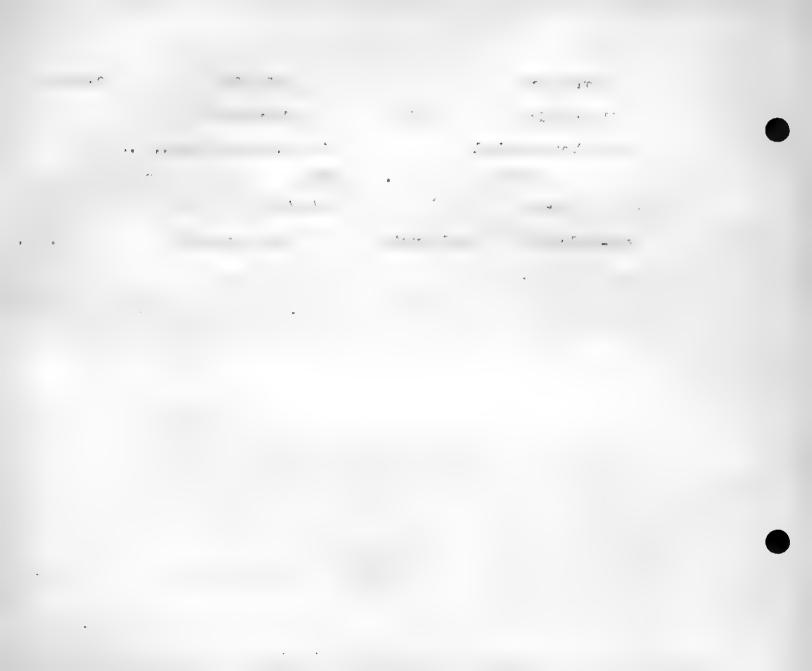


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09713 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death death funeral 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission a. COUNTY b. COUNTY tely filled in by the function papers. Pages 1 c within 72 haurs after d Montgomery MARYLAND b. CITY OR TOWN (If autside carparate limits C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RJRAL and give nearest town) write RURAL and a ve nearest tawn Washington mo. Silver Sprin d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RES DENCE ON A FARMS filled Holu Cross Hosp, tal NO X 1301 YES and completely fi 3. NAME OF Middle 4. DATE First Year DECEASED Da5501 19 6/ (Type or pont) DEATH S£X AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE 8 DATE OF BIRTH 7. MARRIED NEVER MARRIED in May eve last birthday) White temalo WIDOWED DIVORCED 9.5 12 CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) **COUNTRY?** INDUSTRY 4.5. Massachusetts 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME or remayal, Patrick Leary Ellen Calnan attending p IS WAS DECEASED EVER IN U.S ARMED FORCES? 17 INFORMANT Address 16 SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give wor or dates af service) Mrs.Nell Leary4550Conn.Ave.N.W.WashDC cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) signed by the burial-transit p burial, crematic PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) physician. DUE TO Canditions, if any, which gave nse ta immediate cause (a). DUE TO stating the underlying cause Q) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO (H) TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS 1 PERFORMED? be retained by the hospital ar 20g ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm. 20c TIME OF INJURY Month, Day, Year (City or town) (County) (State) factory, street, office blda, etc.) Haur a.m. Not While 19 at work at work O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) aftended the deceased fram that (I) (we) last saw the deceased alive an and that death accurred at causes on the date stated above 22a SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v DIRECTOR 22c. PHYSICIAN 22d. ADDRESI John Curry J. 23c NAME OF CEMETERY OF CREMATORY 23d LOCATION (City or Toyon) (State) 230 BURIAL CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify) Olivet Washington, D. Mt. ADDRESS 250. REC'D BY REGISTRAR VR A15 (4) 1 HAH 26 34 21 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09719 CERTIFICATE OF DEATH papers Pages I and... 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH requires that the death certificate be executed within 24 havrs after dea b. COUNTY Montgomery o STATE Maryland o. COUNTY MARYLAND b CITY OR TOWN (If ourside corporate firmits, write RURAL and give nearest town) campletely filled in by the lave carbon papers Pages c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E LENGTH OF STAY IN 16 3 illeeks Kensinotan Illheaton e IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS ON A FARM? 901 Arcola Ave. 11225 Newport Mill Rd. YES NO K University Nursino Home v,thn 4 DATE Dov Year 3 NAME OF Middle Lost Month DECEASED Davis Nolia July 19. 19 67 Margaret DEATH (Type or print) IF INDER I YEAR | IF UNDER 24 HRS AGE (In years S SEX DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED attending physician and camp sermit. Then please remave crematian, ar remaval, and in any ev birthdoy) Months Doys Hours 4/12/1903 Female Caus. WIDOWED DIVORCED 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT IDa JSUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) INDUSTRY COUNTRY? Hazelton, Pennsylvania IISA Housewife 14. MOTHER'S MAIDEN NAME (Unknown) Edwards James Jones 11227 Newbort Mill 17 INFORMANT Son 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) 553-52-7115 George A. Davis -Kensington, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY ONSET AND DEATH burial-transit tar am 50511 IMMEDIATE CAUSE (o) signed by TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by DHE TO burial, PRIERIOSCIEROTIL CEREBROYASCULAR Conditions, if any, which gove rise to immediate couse (a). DUE TO storing the underlying couse detached far use as the e Dept af Health priar ta lost 19. WAS AUTOPSY PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO V 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year factory, street, office bldg , etc.) at work ot work . 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram "? 1967. ta 1967, and that death accurred at 1 A M, fram causes and an the date stated above saw the deceased alive an directar, page 3 sho shauld be filed with 22b DATE SIGNED 220. SIGNAZURE STAFF PHYS DIRECTOR M.D. 22d. ADDRESS 22c PHYSICIAN'S COMMECTICUT ARE NAME (Type) RICHARD 10403 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 230 BURIAL, CREMATION. 23b DATE THEREOF BENOVA (Serrity) Monocacy Cemetery Beallsville, Maryland 7-22-67 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATUR **ADDRESS** 24 FUNERAL DIRECTOR VR A15 (4) PUMPHREY, Bethesda, Maryland DATE . 20 M 1/66

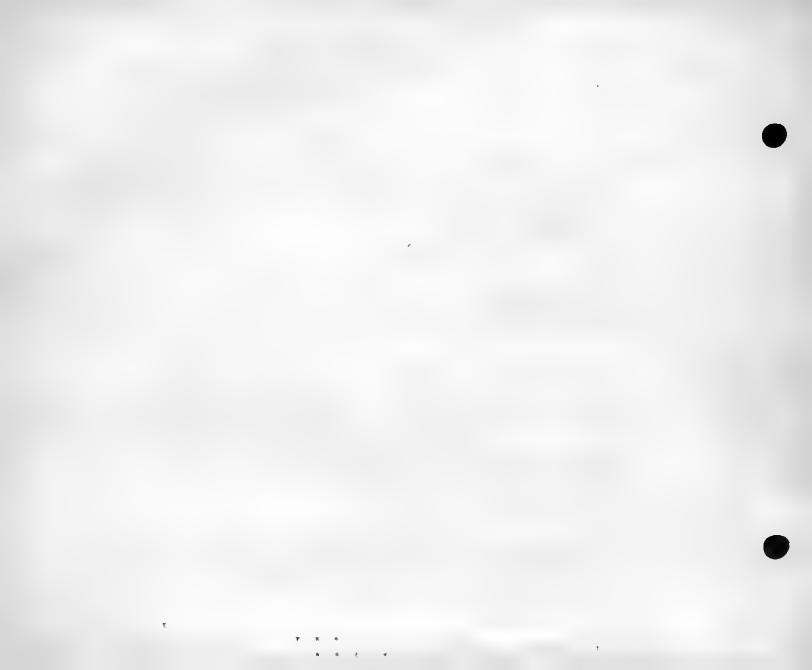
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d be ( d 'pel Chief, trans't	1 Acute coronary insufficiency  420   DUE TO  Conditions, if any, which gove ) (b) Arterioscleration heart disease								INTERVAL BETWEEN ONSET AND DEATH		
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EXAMINER: cute the certificate 4 shauld your files Page 3 shaul cremation, a	ADI SON I	IME OF INJURY Hour o.m p.m	Month, Doy, Year	While	INJURY OCCURRED  e Not While  rk otwork		CE OF INJURY (Home, ory, street, office bldg		(City or town)	(County)	(Stote)
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TO DEPUTY MEDIC, necessary, please e the funeral director 5 may be retained for FUNERAL DIRECT Health pr ar ta burin	NAME	INER'S (Type) 3	ELDE	N_/	1/1/	AF	MD Address .	FD.CA. EXAMINI	Figr county)	1241	1967
the Hear		(Specify)	23b DATE	27. 196	23c. NAME OF LE	incol	_		ince Geor	own) Lou	M-1 (31018)
VR A15ME (5)		SE DIRECTOR		Inc.	8434 Geor	gia Ai	venue 250 Maryland	REC D BY REGIS	TRAR 1967	REG STRIKE STONE	Judges



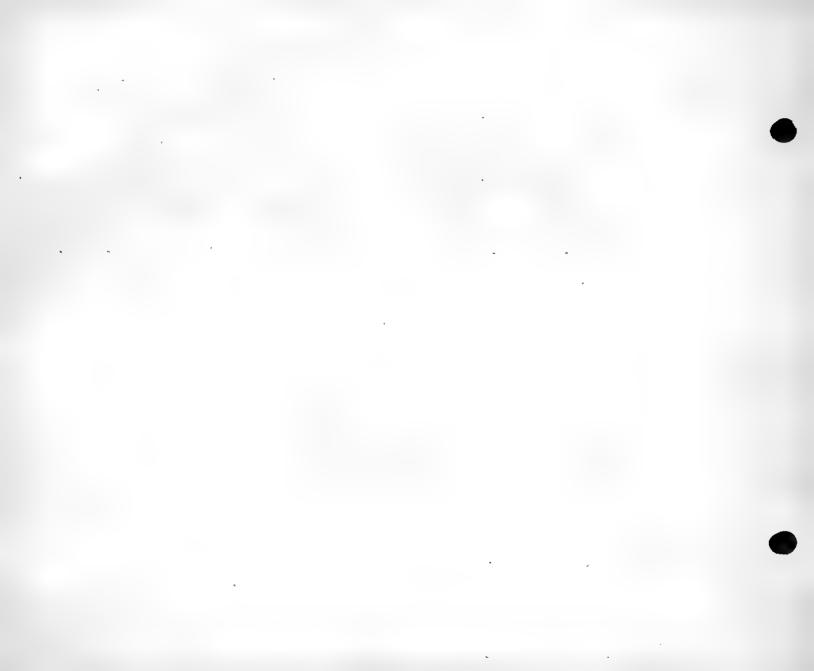
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH フロロー and 2 death. funeral ). PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Montgomery b. COUNTY by the rong papers. Pages 1 c MARYLAND Maruland Montanmery requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neglest town) write RURAL and give nearest town) Sparia 30 HEGTA d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? ≘ d. STREET ADDRESS filled 1314 Cresthaven Drive 1314 Cresthaven Drive within, YES NO IC 4. DATE NAME OF Middle Month S First Doy Year campletely DECEASED OF DEATH Elizabeth July 26 19 67 Carl IF JNDER 1 YEAR | IF UNDER 24 HRS S SEX 9. AGE (In years 6 COLOR OR RACE 7. MARRIED EXI NEVER MARRIED remove lost birthdovi Months Dovs Hours temale white WIDOWED DIVORCED physician and KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT COUNTRY? please during most of working ite, even if retired) INDUSTRY Hampton, Virginia Own home 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar removal, Susan Jane Rulitant John M. Walker WAS DECEASED EVER IN J.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO Cresthaven Drive (Nes. no, or unknown) (If yes give wor or dotes of service 14-05-2561 Herman M. Dila INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY Carcinoma of Colon IMMEDIATE CAUSE (o) DUE TO over one Conditions, if ony, which gove (b) rise to immediate couse (a), vear DUE TO stating the underlying couse attending as the priar tak has been PHYSICIAN: The fow 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) be detached far use State Dept. of Health NO K O FUNERAL DIRECTOR: After this certificate by the haspital ar 200 ACCIDENT WAS UNDERLYING [ 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING FIT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While of work ATTENDING ot work May 29 , 19 67 , to July 26 , 19 67, that (1) (4) last 21. I certify that (1) (this hospital) attended the deceased from\_ be retained director, page 3 should should be filed with the and that death accurred at 9:354M, from causes and on the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. 7/26/67 DIRECTOR M.D 22d. ADDRESS PHYSICIAN'S NAME (Type) Norman H. 11161 New Hampshire Ave. S. S. Md. Rubenstein, MdD. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BUR AL, CREMATION (County) (Stote) REMOVAL (Specify) Fort Lincoln Cemetery Prince Georges adentakons RECD BY REGISTRAS. 250 25b, REGISTRAR'S SIG VR A15 (4) 9.10. 20 M 1/66 - uniohteu.



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completely filled ave carbon page y event, within 77	3 NAME OF First DECEASED (Type of print) Joseph	Middle Christopher	Lost 4 DATE	Month Day Year July 30 19 67
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can ord ease rem and in an	during most of warking life, even if retired) IND Fireman Fir	D OF BUSINESS OR USTRY Te Protection	11 BIRTHPLACE (County & State, ar fareign country, Ireland	12 CITIZEN OF WHAT COUNTRY? USA
is death certificate by attending physican permit. Then please ian, ar removal, and i	13. FATHERS NAME Thomas Dillane		14. MOTHER'S MAIDEN NAME  Catherine McNamara	
ne death atendin permit. ian, ar re	(Yes, no, or unknown) (If yes give wor or dates of service)	OCIAL SECURITY NO 17. IN 32-32-2424 Cer	<sup>FORMANT</sup> The Medical Reco Ster, Bethesda, Maryla	rds; The Clinical
physician, physician, signed by the burial transit burial, cremati	Canditions, if any, which gove nse ta immediate cause (a), stoting the underlying cause	o), (b), and (c).)  Diratory Insuff  Diblastic Garci	iciency inoma Metastatic to In	interval Between 2 months  3 months
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ay be rei	22c GHYSTCIANS	MD	ATTENDING MED STAFF PHYS DIRECTOR PHYS  22d. ADDRESS The Glinical	© 30 July 1967
TO HOSPITAL OK ATTEN Page 4 may be retained TO FUNERAL DIRECTOR: director, page 3 shou c should be filed with the	NAME (Type) William E. Bridsc  230 BURIA. (REMATION, 23b DATE THEREOF	on, M.D.  230 NAME OF CEMETERY OR C	Institutes of Health	or Town) (County) (State)
VR A15 (4)	BURIAL  7/31/1967  24 FUNERAL DIRECTOR  HYSONG STRIMBERAL HOME	ADDRESS WASH	D • G • 250 REC'D BY REGISTRAR 2	NEW YORK CITY, NY Sb. reg strar s signature  y Clianley Yungan



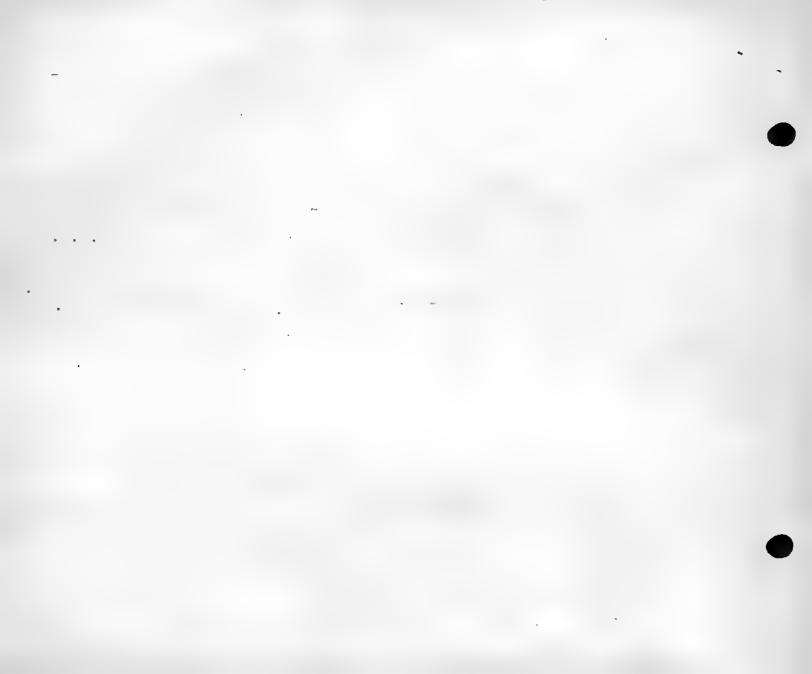
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. COUNTY MONTGOMER o. COUNTY o. STATE Poge MARYLAND ONTGOMERY C LENGTH OF STAY IN IN r CITY OR TOWN (If autside carparate hmits, write RURAL and give negrest tawn) puo write RURAL and give nearest town VER SPRING e. IS RESIDENCE d NAME OF HOSP TAL OR INSTITUTION ( final in hospital give street address) d. STREET ADDRESS ON A FARM? 8. Give Poges hours after deoth 3. NAME OF Middle 4. DATE Year DECEASED RTHUR ACA 19 67 (Type or print) ILLON DEATH alona S SEX 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH NEVER MARRIED last birthday) Months Hours WIDOWED DIVORCED event 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Mc Clouth, Kansas Chief Med-cal Examiner's 13. FATHER'S NAME penci George 9. Dillon Emma Jones 17. INFORMANT Parkside Road 16. SOCIAL SECURITY NO or removal. (Yes na, or unknown) (If yes give war ar dates af service) Alethea B. Dillon Silver Spring 18 CAUSE OF DEATH (Enter only one cause per NTERVAL BETWEEN PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) used as a burial-tra burial, cremation, a This certificate should writing the word DUE TO Canditians, if any, which gave rise ta immediate cause (a). stoting the underlying couse 19 WAS AUTOPS)
PERFORMED? PART ILLOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ILIQ the certificate. its designated ogent, prior to 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item IB.) PR MARY Or CONFRIBUTING CAUSE OF DEATH. 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or town) (County) (State) Hour a.m. Nat While factory, street, affice bldg, etc.) moy be retained for your FUNERAL DIRECTOR: Poge 21 I certify that I taak charge of the remains described above, held an Autopsy 1 Inspection D. Inquiry XI. and in my apinian Natural causes director. death resulted fram: Suicide Undetermined manner Hamicide ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funerol O DEPUTY the funeral 5 may be r 70 FUNERAL Health or it DEPUTY MEDICAL EXAMINER **EXAMINER'S** 23d LOCATION City or Town 23a BURIAL CREMATION (County) REMOVAL (Specify) August 4. 1967 Colesville Methodist Cem. Colesville, Maryland Cate 8434 ADORES gia Avenue VR A15ME (5) arner E. Promphrey. Inc. Silver Spring, Marylom 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 69729 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE **b.** COUNTY Montgomery Montgomery Maryland MARYLAND b CITY OR TOWN (If outs de carparate limits, write RURAL and give necrest tawn)
SILVER SPRING C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RES DENCE ON A FARM? Holy Cross Hospital 3608 Randolph Rd within NO carban NAME OF Middle 4. DATE Last Month Year completely DECEASED Benjamin-Franklin-Dixon 67 (Type or print) 19 DEATH 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years IF JNDER IF JNDER 24 HRS 7. MARRIED NEVER MARRIED lost burthday) Manths Hours white 3 - 17 - 05and in any WIDOWED DIVORCED and 1Do USUAL OCCUPATION (Give kind of work done IDE KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? attending physician sermit. Then please Davidsonville. Md carpenter 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME ar removal, Eldridge Edwin Dixon Frances Phipps 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO Address 3608 Randolph Rd (Yes, no, ar unknown) (If yes give war or dates of service) 577-22-0730 Mrs. Amelia Dixon crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY: (wife) signed by the burnal-transit FIBRILLATION. PENTRI CULAR IMMEDIATE CAUSE (a) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital or attending physician. 11.201 DUE TO Canditions, if any, which gave THROMBOSIS rise to immed ate cause (a), DUE TO stating the underlying cause of Health prior to as the ME Dica ATHEROS CLEROSI last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) PERFORMED? YES NO far 20o ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER BX 20c. TIME OF INJURY Month, Day, Year Haur a.m. 2Dd INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or fown) (County) (State) factory, street, office bldg., etc.) Nat While of work 21. 1 certify that (1) (this haspital)\_attended the deceased from\_ O FUNERAL DIRECTOR: sow the deceased alive on. July 15 22a SIGNATURE 225 DATE & GNED ATTENDING M.D DIRECTOR PHYS 22d ADDRESS PHYSICIAN S MO NAME (Type) 10100 JURIAL CREMATION, CEMEJERY OR CREMATORY 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05736 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs ofter death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY Montgomery b. COUNTY Maryland Montgomery MARYLAND E. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and campletely filled in by the remave carban papers. Pages r LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, Silver Spring write SPATOW & PreSPAMP) TO e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 3709 Elby Street Holy Cross Hospital YES NO P and in any event, within 4 DATE Month Year NAME OF First Middle Last 19 67 OF DEATH July DECEASED Burgess  $\mathbf{E}$ Dodson (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years B DATE OF BIRTH SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** lab Thdoy) Months Doys Hours White 10-3-1904 Male WIDOWED DIVORCED 11 BIRTHPLACE (County & Stote, or foreign country)
Virginia 12 CIT ZEN OF WHAT 106 KIND OF BUSINESS OR 100 USJAL OCCUPATION (Give kind of work done COPNIS? A. please dang day of Morking the trade fremed) signed by the attending physician burial-transit permit. Then please 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME burial, crematian, or remaval, Luther Dodson Ida 2006Ad Rockland Ave. Son 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAC SECURITY NO (Yes, no or unknown) (If yes a ye was or dates of service) 579-07-9886 - Rockville, Md. Upton L. Dodson INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) MYOCARDIAL INFRICTION be retained by the haspital ar attending physician. ARTERIOSCLEROTIC HEART DISEASE Vens Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse director, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health prior to this certificate has been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO DO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e PLACE OF INJURY (Home, form, (City or town) (County) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) Hour o.m. TO FUNERAL DIRECTOR: After \_, 19<u>6</u>->, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram\_\_\_\_ , 1967, ta 7/15 19 67, and that death accurred at 5 PM, from causes and an the date stated above. saw the deceased alive on. 7/18 22b. DATE SIGNED 220 SIGNATURE **ATTENDING** alle DIRECTOR M.D. 22d. ADDRESS 22c PHYSICIAN'S 10 YOU CONNECTICUT AVE ICHARD POLLEN NAME (Type) MD 23d. LOCATION (City or Town) (County) 23c. NAME OF CEMETERY OR CREMATORY 23o BUR AL, CREMATION, 23b DATE THEREOF Burial Burial Beallsville Mary 7-18-67 Monocacy Cemetery 250. REC'D BY REG STRAR **JUNERAL DIRECTOR** Bethesda, Maryland Mariles VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission), PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Montgomery Pennsylvania MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) 72 hours o 17 Davs Easton 9 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? led F The Clinical Center, Bethesda, Maryland 505-B Charles Street YES NO D within 3 NAME OF First 4. DATE Lost Month Day Year DECEASED (Type or print) Dold Joseph 67 July 19 August DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lost birthday) Months Doys Hours ond in any Male White WIDOWED DIVORCED March 1920 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT COUNTRY? 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) physicion o during most of working life, even if retired) INDUSTRY Pennsylvania Laboratory Technician USA 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Emily Miller John Dold 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO The Medical Recofd's' The Clinical Center, Bethesda, Maryland Yes 203-09-1999 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART 1 DEATH WAS CAUSED BY: ONSET AND DEATH Cardiac Arrest IMMEDIATE CAUSE (a) DHE TO Conditions, if any, which gove Status Epilepticus 38 hours ase to immediate cause (a), DUE TO stating the underlying couse os the l Page 4 moy be retained by the hospital or attending (d) Craniopharyngioma vears WAS AUTOPSY DIRECTOR: After this certificate hos PART IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? YES X NO Ē 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I of Port I of Item 18) 20o ACC DENT WAS UNDERLYING I detached for te Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg, etc.) Not While nt work at work , 19 67 , to July 20 , 19 67 , that (X) (we) last 21. I certify that (X) (this hospital) attended the deceased fram\_ July 3 19 67, and that death accurred at 35 M, from causes and an the date stated above saw the deceased alive an July 20 220 SIGNAPURE 226 DATE SIGNED ATTENDING 20 July 1967 director, poge 3 should be filed v PHYS M.D. 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Robert A. Ratcheson, M.D. Institutes of Health, Bethesda, Md. 23c. NAME OF CEMETERY OR CREMATORY 23g BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23d LOCATION (City or Jown) (Stote) (County) CASTON 2Sq. REC'D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 7400 GEORGIA HUE. N.W. 25M 1/67 INALDI TUNECAL HOME LUX



MAKTLAND STATE DEPAKTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours ofter death death funeral 2 USUAL RESIDENCE (Where deceased lived, if institution. Residents be all admission. puo PLACE OF DEATH o. COUNTY Maryland b. COUNTY Montgomery Montgome ry MARYLAND by the Pages b. CITY OR TOWN (If autside carporote imits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparote limits, write RURAL and give negrest town) write RURAL and give nearest town) VR5 Wheaton Wheaton d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? filled 2608 Weisman Road 2608 Weisman Road YES NO 🔀 NAME OF Middle ond completely remove corbon 4 DATE Last Month Yеаг Doy DECEASED (Type or print) FRANCIS OF J. DUNN July 29, 67 DEATH S SEX 6 COLOR OR RACE IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR last birthday) Manths Davs Male White Jan. 26, 1902 WIDOWED DIVORCED 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life even fretired). Wheaton Dorr COUNTRY? attending physicion sermit. Then please Penna. U. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, or removal, Peter Dunn Frances McDermott 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Wife Same as Item 2. (Yes, no or unknown) (If yes give war or dates af service) Elizabeth J. Dunn. 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). INJERVAL BETWEEN the burial-transit PART I. DEATH WAS CAUSED BY: NSEL AND DEATH IMMEDIATE CAUSE (a) è DUE TO signed buriol, Li Carcinomi Conditions, if any, which gave nse la immediate cause (a), DUE TO stoting the underlying couse hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELETED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160 WAS AUTOPSY PERFORMED? this certificate NO SK OR ATTENDING PHYSICIAN: ö 20a ACCIDENT WAS UNDERLYING □ (Enter nature of injury in Part 1 or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour to m. Not While factory, street, office bldg., etc.) at work at wark Page 4 may be retained by 21. 1 certify that (1) (this hospital) attended the deceased from DIRECTOR: sow the deceased-alive on and that death accorred at 6 227 M, from cause and on the date stated above. 22g SIGNATURE 226. DATE SIGNED ATTENDING M.D DIRECTOR director, page should be fired Viers 22c PHYSICIAN S 22d ADDRESS 809 FUNERAL STEPHEN **JONES** NAME (Type) Rockville. Md 23d LOCAL ON (City or Lown) (Co 230 BUR AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County)
Mont Gate of Heaven 8-1-67 2 24. FUNERAL DIRECTOR ADDRESS 2So REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 7557 Wisconsin Ave A Pumphrey 196 Bethesda, Md

MARYLAND STATE DEPARTMENT OF HEALTH A PROPERTY Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY District Of Columbia COUNTY Montgomery the attending physician and completely filled in by the fit sit permit. Then please symble carban papers. Pages I nation, ar remayal, and in any event, within 72 haurs after MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after E. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write Park I real propagation of town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12Mos 3 Davs Washington d. STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4361 Nichols Ave. S.E. WDC Hospital NO TA Naval NAME OF 4. DATE First 1967 DECEASED (NMN) DWYER Charles signed by the attending physician and complete burial-transit permit. Then please remove carb burial, cremation, ar removal, and in any event, (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED **NEVER MARR ED** birthdoy) Months Hours Cauc Male Dec.23.1906 WIDOWED DIVORCED 12, CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) 10c USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) Military Crab Orchard, Illinois 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME TRAVELSTEAD Edward L. Nora DWYER 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or unknown) (Lives give wor or dates of service) 299-50-47 Isabel M. Dwyer 4361 Nichols Ave S.W. WDC INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Arteriolosclerotic Cerebral vascular disease ONSET AND DEATH IMMEDIATE CAUSE (8) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital or attending physician. severe with intracerebral vascular aneurysm DUE TO 21 Conditions, if any, which gove Squamous cell carcinoma of larynx post operative rise to immediate couse (a). DUE TO stoting the underlying couse GENERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the should be filed with the State Dept. of Health priar to WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CFRTIFICATION NO [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) \*28 July 198 6 to 31 July 191 , that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 31 July 19 67, and to 19 67, and that death occurred at 7:41 BM, from causes and on the date stated above. 22b. DATE SIGNED 220 SIGNATURE STAFF PHYS. **ATTENDING** AUG. 1 1967 M.D. DIRECTOR Naval Hospital, Bethesda 22c. PHYSICIAN'S CAVANAGH NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL CREMATION. (County) BREMOVAL (Specify) Arlington, National Arlington, Va. 8.4.1967 2So. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR DATE AUG VR A15 (4) 20 M 1/66 4th&Massachusetts .N.E. Home Lee Funeral



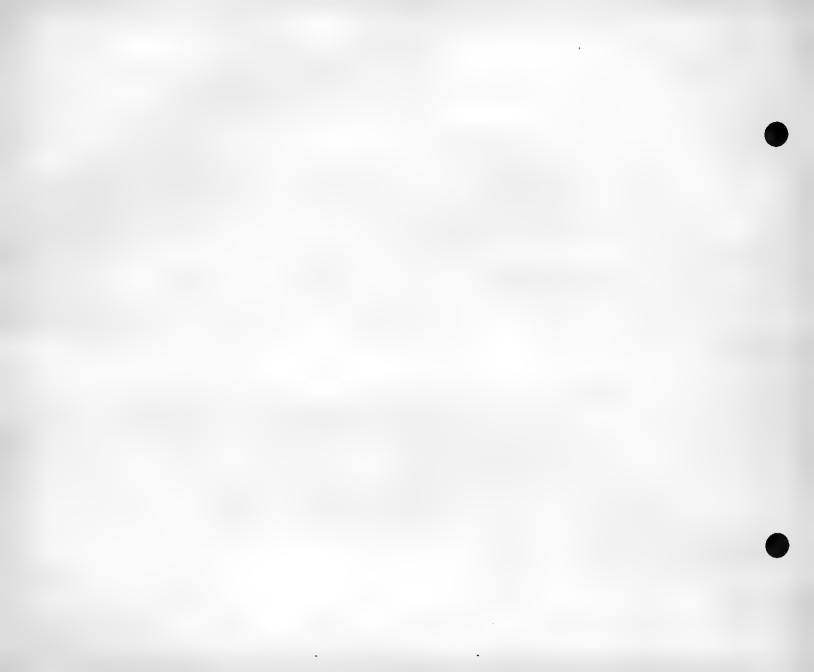
		MARYLAND STATE DEPARTMENT OF HEALTH
A CONTRACTOR OF THE PARTY OF TH		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12 Am
FOR :	STATES	09729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH	1 DERL	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased year, if institution Residence before admission) a COUNTY  5 COUNTY
way delay is , 2, and 3 to PM3. Page	0	MARYLAND Mareline Minley use
delay and 3	ment of	b CTY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)
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4 hours ofter death H on them 18. Give Pages 1, s Office olang with form	TE IF	Deverben Hegeld #809 Leland Street YES NOV
ofter death 8. Give Page olang with f		3 NAME OF OF STATE Month Doy Year OF STATE OF ST
er o	the	GECEASED (Type or print) Column Sacrason Gastham OF DEATH July 16 1967  S SEX 6. COLOR OF RACE 7 MARRIED IN NEVER MARRIED 18 DATE OF BIRTH 9 AGE BAYBOTS DIFUNDER 1 YEAR FUNDER 24 HRS
off olar	with .	dust birthdoy) Months Doys Hours Min.
hours Item 18 Office o	and 2 death	7.00
24 hours n Item 1 's Office	lar er d	demonstrated working life, even if retired) IND. STRY 7126 Was 20 COUNTRY 20
n 24 il n l	poges urs off	13 EATHERS NAME 14 MOTHERS MAIDEN NAME
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rute ig:	permit.	(Yes, no. or ak(nown) (1 yes g ve wor or dotes of service) 21722.5450 Mr. Rahert Eastfrom, Su (500)
d be executed within 2 d "pending" in pencil i Chief Medicol Examiner	tronsit permit. File pages 1 and 2 w event within 72 haurs ofter death.	18 CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c))
be "pe	onsit	PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) COTOD 219 In 30853 Cancy Acata 30851 AND DEATH
shauld e ward o the Ch	burial-transit	1201 DUE TO
sha e w	buriol in any	Conditions, if only, which gove (b) Cordio Vascular Diarase - Years
of the day	9.5	stoting the underlying couse DUE TO
ertificate sh writing the	d as q	lost (c)
- 5	be retained for your files.  RAL DIRECTOR: Page 3 should be used prior to burio, cremotion, or removal,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(0)  19 WAS AUTOPSY PERFORMED?  PERFORMED?
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= =	should on, or r	PERFORMED? YES NO NO NOTION PORT LOT PORT LOT PORT LOT ITEM 18.)  PERFORMED? YES NO NO NOTION PORT LOT PORT LOT ITEM 18.)
EXAMINER: tute the certificate 4 should	files. 3 shor fion,	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form form factory, street, affice bldg, etc.)  20f (City or town) (County) (State)
\$ <del>+</del> 4	your Poge :	Hour a.m.  Pm 19 While at work at While of work at work
L EXA ecute Page	for y	21. I certify that I taak charge of the remains described above, held an Autapsy , inspection K, Inquiry , and in my opinion
	DIRECTOR: Page to burio, cremo	deoth resulted fram: Natural causes X, Accident , Suicide , Homicide , Undetermined manner
trect	oine IRE(	ACTUAL O 2 0 13.00 CHIEF MEDICAL EXAMINER  22 DATE SIGNED
	I D	SIGNATUREMD ASSISTANT MEDICAL EXAMINER []
OUT Sory	may be r FUNERAL catth prior	EXAMINER'S  NAME (Type)  DEPUTY MED CAL EXAMINER & 7/6/67 CTY MD.  Address (Street, "Ty, town, or county) Man Town For CTY MD.
O DEPUTY MECCA necessory, please ex the funeral director	5 may be retoined 0 FUNERAL DIRECT Health prior to buri	NAME (Type)  230 BUR AL CREMATION, 23b DATE THEREOF 23r NAME OF CEMETERY OR CREMATORY 23d LOCATION (Ay or Two) (County) (Stote)
<b>5</b> 5 4	~2±	REMOVAL (Specify)
200	A DELLE IE. VIII	24_FUNERAL DIRECTOR ADDRESS 250_RF7.0*BY REGISTRAR 1 256_RF7.0*BY REGISTRAR 2 5 GNATURE
	A 15ME (5) M 1/67	Joseph Jawler's ons, Inc. JUL 20 1967 Guerlas Judge
		The state of the s



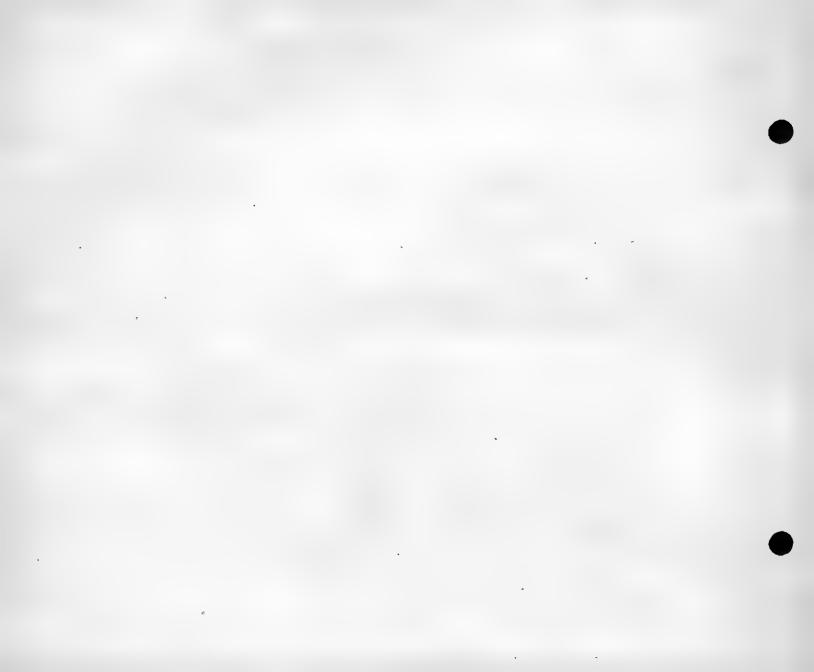
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 89735 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) COUNTY **b** COUNTY MARYLAND TOWN (1) outside corporate L E. LENGTH OF STAY IN 16 OR JOWN (If outside corporate limits, write RURAL and give nearest town HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS 6 IS RESIDENCE ON A FARM? YES NO 🔀 NAME OF DATE Doy Year DECEASED (Type or print) 19 6 DEATH IF UNDER 1 YEAR IF JNDER 24 HRS 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years NEVER MARRIED lost birthday) Months Dovs WIDOWED DIVORCED non) and 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working like, even if retired) INDUSTRY **COUNTRY?** Schools 13. FATHER'S NAME Augustas Edes 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service 0 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING OF DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS)
PERFORMED? NO 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) 20o ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) (State) foctory, street, office bldg., etc.) Not While of work 21. I certify that (1) (this haspital) attended the deceased fram and that death accurred at 438 M, from causes and an the date stated abave. O HOSPITAL OR ATTEND Poge 4 may be retained saw the deceased alive or 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22c. PHYSICIANZ 22d, ADDRESS NAME (Type) 23o. BURIAL, CREMATION, REMOVAL (Specify) Burial 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (County) Baltimore National Baltimore, Maryland 24. FUNERAL DIRECTOR
Tyson wheeler Funeral Home-1331 Rockville Pike
DATE 2Sa REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATUR Rockville Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY o. STATE b. COUNTY montgomery Marulana MARYLAND led in by bapers Pages b CITY OR TOWN (If outside corporate limits) c. LENGTH OF STAY IN 1b. c CITY OR TOWN At outside corporate limits, write RURAL and give neglect town) write RURAL and give nearest town? Silver Silver d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCI ON A FARM? filled 1.1 Noly Cross Hospital YES NO DR NAME OF Middle DATE Lost Month Doy Year DECEASED JASPIDA Embree (Type or print) MMIN DEATH 21 1967 IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Doys Hours White ond in any WIDOWED DIVORCED 12 CITIZEN OF WHAT TOO USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1), BIRTHPLACE (County & Stole, or foreign country) during most of working life, even if retired) COUNTRY? \_ INDUSTRY Air conditioning air conditioning 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol. William Lewis Embree Jenina Josephine Bell 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service Grove Street 218-24-629 ues cremation, TB. CAUSE OF DEATH (Enter only one couse per line PART I DEATH WAS CAUSED BY buriol-transit IMMEDIATE CAUSE (a) 10 Mas DUE TO bur.al, Canditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse the 19 WAS ALTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) certificate hos PERFORMED? of Health YES X NO 200 ACC DENT WAS UNDERLYING [] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAM, NER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, ((ity or fown) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. Not While foctory, street, office bldg., etc.) of work Page 4 moy be retained by 21. I certify that (1) (this hospital) attended the deceased fram 19 (that (I) (we) lost M, from causes and on the date stated above. saw the deteased give on. and that death accurred at 220. S GNATURE 225 DATE SIGNED ATTENDING PHYS DIRECTOR 22c. PHYSICIAN'S NAME (Type) should 236, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d COCATION (CAY or Town) (County) 23a BLRIAL, CREMATION, (State) REMOVAL (Specify) Rockville. Parklawn Cemetery Maryland 0



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission. .g. COUNTY Maryland b. CQUNTY Montanmery MARYLAND Montaomeru PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after filled in by the fu Then please remove corbon papers. Pages remayol, and in ony event, within 72 hours after b CTY OR TOWN (If outside corporate l.m.ts, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 Silver Spring Silver Spring e IS RESIDENCE ON A FARM? d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8211 Queen Annes Drive Holy Cross Hospital YES NO X 4. DATE Month NAME OF Dov Year First the attending physician and completely isit permit. Then please remove color DECEASED Ethel Dorothy Esten DEATH (Type or print) 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH 7. MARRIED last birthaoy) Months Dovs Hours white Nov 25. 1906 temale WIDOWED DIVORCED 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 100. JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRY? during roost of working life, even if retired) Mass. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Thompson Margaret Phillips Charles H. 16 SOCIAL SECURITY NO 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? Queen Annes Drive (Yes, no, or unknown) (If yes give wor or dates of service) 5 Lewis. cremation. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: burial-tronsit signed by t IMMEDIATE CAUSE (o) by the hospitol or attending physician. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO as the stoting the underlying couse O FUNERAL DIRECTOR; After this certificate has been lost. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o for use ( NO 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Jo Jo detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e PLACE OF INJURY (Home, form, 20f. (City or fown) (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o.m. foctory, street, office bldg., etc.) Not While ot work at work 21. I certify that (I) (this hospital) attended the deceased fram\_ be retained shauld and that death occurred of 2:45 AM, from couses and on the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING DIRECTOR M.D PHYS. PHYS. director, poge should be filed 22d. ADDRESS 22c PHYSKIAN'S NAME (Type) urry 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 23b. DATE THEREOF BURIAL, CREMATION REMOVAL (Specify) Cedar Hill Cemetery Suitland, Maryland 2Sb REGISTRAR S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



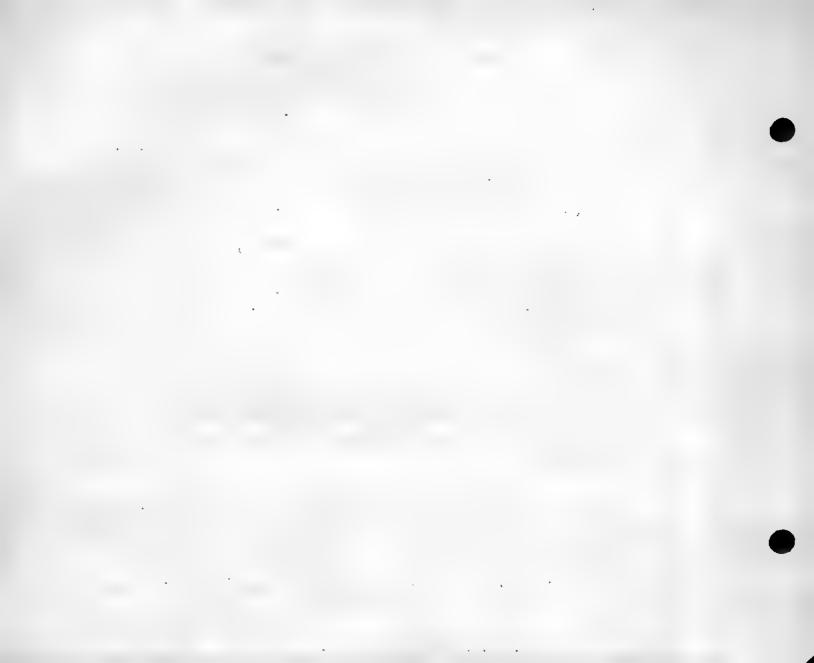
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) p. COUNTY b. COUNTY MARYLAND within 72 hours after b CITY OR TOWN (If outside corporate I mits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) wite RURAL and givernearest town) .≡ papers. INSTITUT ON (If not in hospital, give street address) IS RESIDENC ON A FARM 3 NAME OF Middle гетоже согбал campletely DECEASED and in any event, (Type or print) DEATH The law requires that the death certificate be executed s SEX 6. COLOR OR AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS 7 MARRIED B. DATE NEVER MARRIED lost b rthdoy) Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) attending physician sermit Then please MOTHER'S MAIDEN NAME burial, crematian, ar removal, 52.2 A 16. SOCIAL SECURITY NO 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service permit 1B CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) INTERVAL BETWEEN the signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Cerebralinfarction right temporal lobe IMMEDIATE (AUSE (o) Page 4 may be retained by the haspital or attending physician. DHE TO Conditions, if ony, which gove 3 Thrombatic occlusion of: right vertebral artery rise to immediate couse (a). DUE TO stating the underlying couse certificate has been be detached for use as the State Dept. af Health prior to right subclavian aterv 9. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(6) Status post right subclavian innominate endarterectory YES 🔀 NO 20o ACCIDENT WAS JNDERLYING T 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Doy, Year 29d, INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. foctory, street, office bidg, etc.) Not While After ot work of work 21. I certify that (I) (this haspital) attended the deceased from MAY. 19/05 10 7-6 . 1962, that (I) (we) last age 3 shauld be 19 6), and that death accurred at 1/20 PM, from causes and on the date stated above. DIRECTOR: saw the deceased alive on 220 SIGNATURE DATE SIGNED **ATTENDING** DIRECTOR r, page be filed 22d ADDRESS 8218 Wisconsin Ave. Bethesda, Md. FUNERAL Francis Mayle, directar, shauld be 22C NAME OF CEMETERY OR GREMATORY 288 COCATION (City or Town) 200 BURIAL CREMATION, (State) DATE THEREOF (County) 9 FUNERAL DIRECTOR 2So REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE VR A15 (4) 1.0

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remove cyclain papers. Pages I and District of Columbia o. COUNTY Montgomery MARYLAND c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate lim'ts, c. LENGTH OF STAY IN 16 write RURAL and give nearest tawn)
Bethesda (Tul 1 day Washington d, NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Naval Hospital 5169 Watson Street, N. W. YES NO 3 3. NAME OF First Middle 4. DATE Month OF DEATH Fechteler (Type or print) William Morrow July 9. AGE ( n years IF UNDER 1 YEAR IE UNDER 24 HRS 6. COLOR OR RACE 8 DATE OF BIRTH eve 7 MARRIED **NEVER MARRIED** last birthday) Months Hours March 6, 1896 burial, crematian, ar remaval, and in any WIDOWED DIVORCED Male Cauc 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, at foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of warking ite, even if retired) **INDUSTRY** San Rafael California U. S. Navy - Retired USA 13 FATHER'S NAME Augustus Fechteler Maud Morrow is was DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknawn) (If yes give wor or dates of service)
Yes 1912—1956 17 INFORMANT N.W. Washington Address 16. SOCIAL SECURITY NO. Mrs. Goldye S. Fechteler, 5169 Watson Street 18. CAUSE OF DEATH (Enter on y one couse per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Dissecting aortic aneurysm IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician.

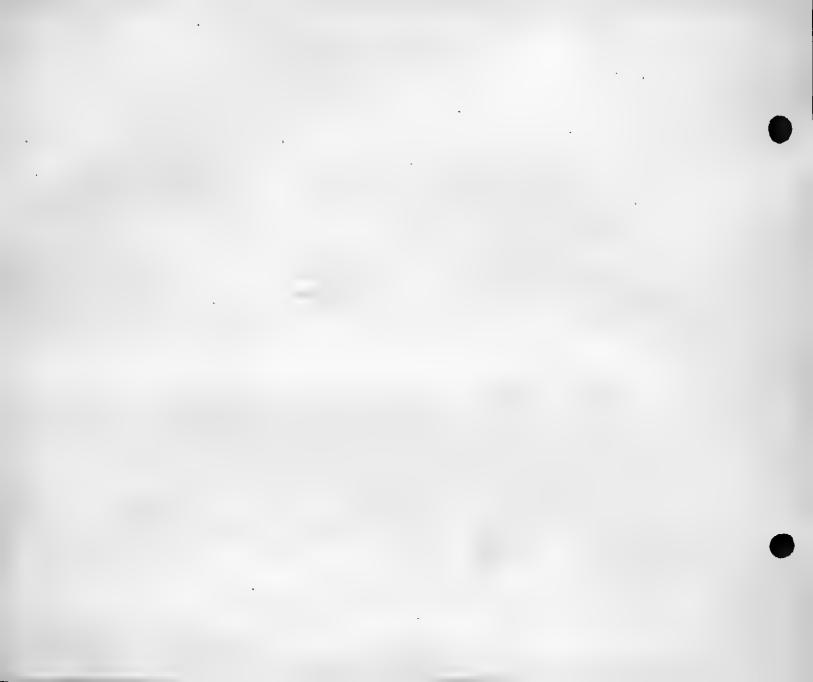
(O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached far use as the burial-tran should be filed with the State Dept. of Health priar ta burial, crer 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO 🔯 20g. ACCIDENT WAS UNDERLYING [ 205 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f. (City ar town) (Caunty) (State) 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, foctory, street, office bldg., etc.) Hour a.m. Nat While at wark at work 21. I certify that (x) (this haspital) attended the deceased fram July 4 , 1907, ta July 4, 1967, that (A) (we) last saw the deceased alive an July 4. 19 67, and that death accurred at 645P M, from causes and an the date stated above. 22g. SIGNATURE 22b. DATE SIGNED MED DIRECTOR STAFF PHYS. 5 July 1967 M.D. PHYS. 22d, ADDRESS 22c. PHYSICIAN'S William R. Hix. M. Naval Hospital. Bethesda. Md. 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Spenty) 7-7-1967 Arlington National Arlington, Virginia 250. REC'D BY REGISTRAR 196 75b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS VR A15 (4) 5130 Wisconsin Ave., N.W. Washington, D. C. DATE 20 M 1/66



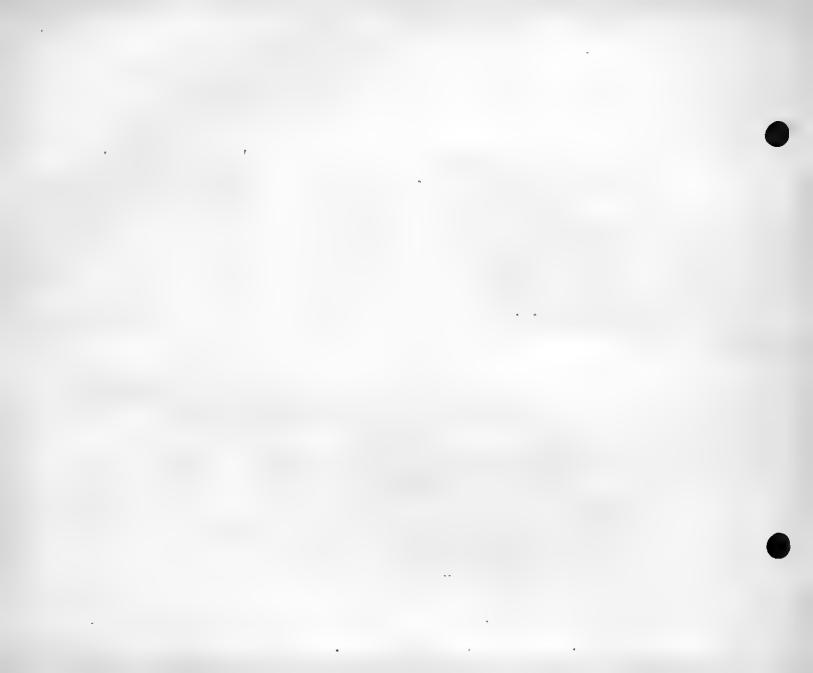
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00735 CERTIFICATE OF DEATH within 24 hours after death funerol PLACE OF DEATH USUAL RESIDENCE (Where deceased eved, if institution: Residence before admission) g. CDUNTY MARYLAND in by the 6 CITY OR TOWN In autside carparate mits, OR ARWN (If autside comarate limits, write RURAL and give negrest taxel) r LENGTH OF STAY IN Th d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? NO F NAME OF DATE Year Sanpletery DECEASED (Type or print) DEATH S SEX 8 DATE OF BIRTH 9. AGE (In years RE UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Dovs OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be exec WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CT.ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Virginia 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, unknown Wright 16. SDCIAL SECURITY ND 17 INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, or unknown) (If yes give war ar dates of service Clarence Swann 260N. 11st. Neward N.J. 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) ) PART I. DEATH WAS CAUSED BY: NTERVAL BETWEEN ONSET-AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gove rise ta immediate cause (a), DUE TO stating the underlying cause PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? NO TO FUNERAL DIRECTOR: After this certificote 20a ACCIDENT WAS INDERLYING 20b DESCRIBE HDW INJURY DCCURRED (Enter nature of injury in Part i or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e, PLACE OF INJURY (Home, farm, 20c TIME OF INJURY Month, Doy, Year 20a INJURY OCCURRED (City or town) (County) (Stote) Haur o.m factory, street, affice bldg., etc.) Not While at work at work 21 I certify that (1) (this haspital) attended the deceased from \_ v / 2-7 , 19 \_ \_\_\_\_ to \_\_\_\_ , 19 \_ \_\_\_\_ that (1) (we) last 4 moy be retained 19. I and that death accurred at MM, from causes and an the date stated above. saw the deceased alive an-22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR director, page should be filed 22c, PHYS CIAN S 22d, ADDRESS O HOSPITAL NAME (Type) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) 23a BUR.AL, CREMATION, REMOVAL (Specify) Pike syille Md. RAR 25b REGISTRAR'S SIGNATURE Druid Ridge Comt. 250 REC D BY REGISTRAR **ADDRESS** 24 \_FUNERAL DIRECTOR VR A15 (4) 25M 1/67 1967 Wilsone



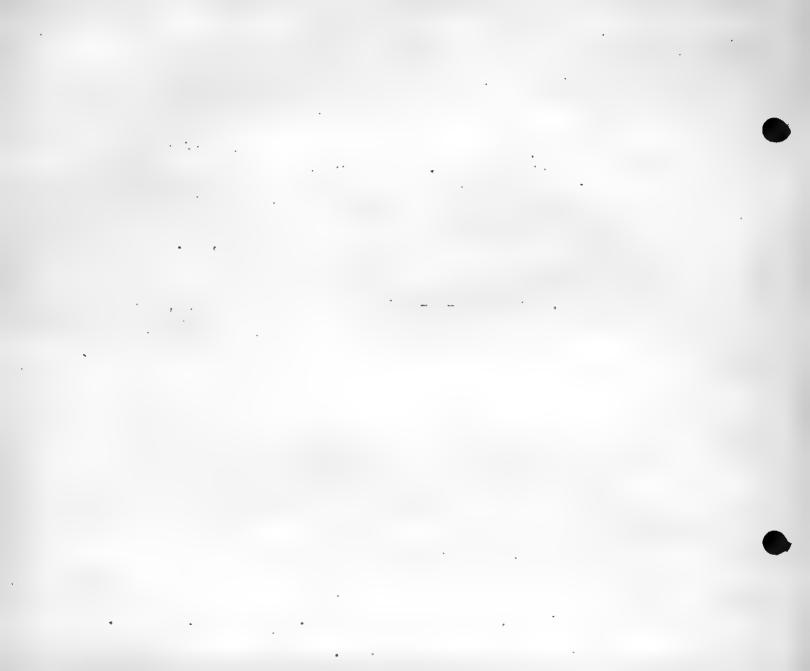
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS ---- BALTIMORE 1, MARYLAND 09736**CERTIFICATE OF DEATH** PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE JINTY b. COUNTY MARYLAND omer 1) Freeze b. CITY OR TOWN of jourside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If autside corporate limits, write RURAL and give/nearest town) RURAMand give heares town) d. NAME OF HOSPITAL/(If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE OR INSTITUTION ON A FARM? YES NO 100 NAME OF DECEASED Middle Last 4. DATE Month Day Year filled OF (Type or print) Pages DEATH 196 IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE 7. MARRIED X NEVER MARRIED B. DATE OF BIRTH AQE (In years last birthday) Months Doys Hours DIVORCED [ WIDOWED [ FemoLe 10a. USUAL OCCUPATION (Give kind of work dame 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S. A. RGINIA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ANC SU physic 15. WAS DECEA¶ED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address attending BN that the death CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO þ Canditions, if ony, which (b) gave rise to immediate DUE TO cause (a), stating the under lying cause last. (c) PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES T NO! 200 ACCIDENT WAS UNDERLYING ☐ OR CONTR.BUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while at wark at wark p. m. 21 | certify that (1) (this hospital) attended the deceased from. 19\_\_\_\_, that (1) Iwell last ond that death occurred of LIM, from the couses and on the date stated above. sow the deceased plive on-FUNERAL DIRECTOR: 22a SIGNATUR 22b. D ATE **ATTENDING** SIGNED PHY5 DIRECTOR PHYS 22c PHYS CIAN S 22d ADDRESS TO HOSPITAL 230 BURIAL CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) (State) page the Str REMOVAL (Specify) CAVEN  $\Diamond$ 0 256, REGISTRAR'S SIGNATUR 24 FUNERAL DIRECTOR'S SIGNATURE 25g REC'D BY REGISTRAR VR ATS (4) DATE 1SM 9/59



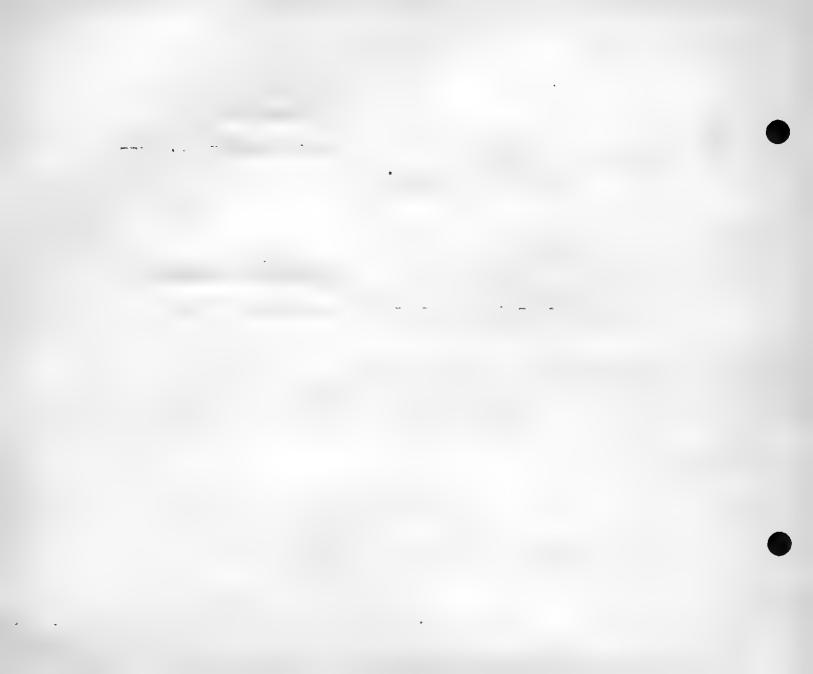
MARYLAND STATE DEPARTMENT OF HEALTH 09734 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05742 CERTIFICATE OF DEATH death. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. COUNTY a. STATE Maryland b. COUNTY Hontgomery Montgomery MARY! AND b City OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside camparate limits, write RURAL and give nearest tawn) Damascus Olnev DOA d NAME OF HOSPITAL OR INSTITUTION (If not in basoital, a ve street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS dod Montgomery General Hospital Box 97, 26008 Ridge Rd. YES □ NO □ within carbon NAME OF Farst Middle 4. DATE Manth Lost Year Day DECEASED Carroll Fetzer 20 1967 (Type or print) DEATH IF UNDER 1 YEAR LIF UNDER 24 HRS S SEX AGE ( n years 6 COLOR OR RACE DATE OF BIRTH 7 MARRIED -C-NEVER MARRIED remove last b rthday) Months Male White 5/9/96 WIDOWED DIVORCED gud 12 CIT ZEN OF WHAT 10a USJAL OCCUPATION (Give kind of work done 105 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) during most of warring life, even if retired) physician c IND STRY **COUNTRY?** Gun Factory Pennsylvania USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME removaľ. William Fetzer Minnie Koser attending poermit. The 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na. ar unknown) (If yes give war ar dates of service) 70 579-09-7977 Hospital Records. Olney, Maryland XYes cremation, 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. NTERVAL BETWEEN signed by the buriol-tronsit p ONSET, AND DEATH A adominal ansuranom IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO buriol, Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause detoched for use as the re Dept, af Health prior to 19 WAS AUTOPSY PERFORMED? After this certificate has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X YES [ 20g ACCIDENT WAS UNDERLYING [17] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Cry or town) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (County) (State) 20c TIME OF INJURY Month, Day, Year factory, street, affice bldg, etc.) Nat While at wark at wark 21 I certify that (1) (this haspital) attended the deceased fram\_ 11124, 26 1967, that (1) (we) last 1967 ta 110.22 16 1967, and that death occurred at 7:05PM, from/causes and on the date stated above FUNERAL DIRECTOR: saw the deceased alive an\_ 22a SIGNATURE 22b DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS 22d ADDRESS 22c PHYSICIANS O HOSPITAL Frederick Moomau Olney. Maryland NAME (Type) director, should be 23d. LOCATION (City or Town) 235 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION (County) (State) REMOVE Specify) July 23,1967 Damascus Meth. Damascus, Md. 2 25b PECISPRARS SIGNATURE ADDRESS 2So REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Olin L. Molesworth. Damascus, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 43 STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND State Department hours after death. CITY OR TOWN (It outside corporate limits, write RURAL end give nearest town) b. CITY OR c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Damascus Olney 2000 d. NAME OF HOSPITAL OR INSTITUTION (if not in bospital, give street affiress) IS RESIDENCE ON A FARM? d. STREET ADDRESS NO YES NAME OF DATE Month 4. Day Middle Last the 72 DECEASED Fishpaw 196 (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. 24 hours after death. If a litem 18. Give Pages 1, Office along with form E P 5. SEX DATE OF BURTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED [ YTS. events 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT BIRTHPLACE (State or foreign country) during most of working life, even if retired) COUNTRY? EXAMINER: This certificate should be executed within 24 hours after certificate, writing the word "pending" in pencil in Item 18. Gishould be forwarded to the Chief Medical Examiner's Office along Salesman AUR Cockeysville MOTHER'S MAIDEN NAME File pages and in any 13. FATHER'S NAME Malcolm Fishpaw Maggie Parks 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) permit. I # W.W. 218-05-6111 Yes Mrs Cathryne Fishpaw Item 2 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (# burial-transit cremation, or cremation. DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating tha 60 used as a to burial, undarlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT CERTIFICATION PERFORMED? YES T NO [ 3 should be agent, prior 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20e, PLACE OF INJURY (Home, farm, ) (County) (State) Month, Day, Year 20f. (Clty or town) TIME OF INJURY 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a.m. Not While While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection. Inquiry director. Page 4 shoul retained for your files. FUNERAL DIRECTOR: Undetermined manner death resulted from: Natural causes Accident Suicide Homicide CHIEF MEDICAL EXAMINER please execute t director. Page 4 ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE or DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health NAME (Type) Address Street, city, town, or county) 23d. LOCATION (City, town or county) NAME OF CEMETERY (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) 70 0 Damascus Meth Burial Damascus 25a. REC'D BY REGISTRAR 25b. SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** DATE VR ALSME (5 Olin L. Molesworth. Damascus. Md

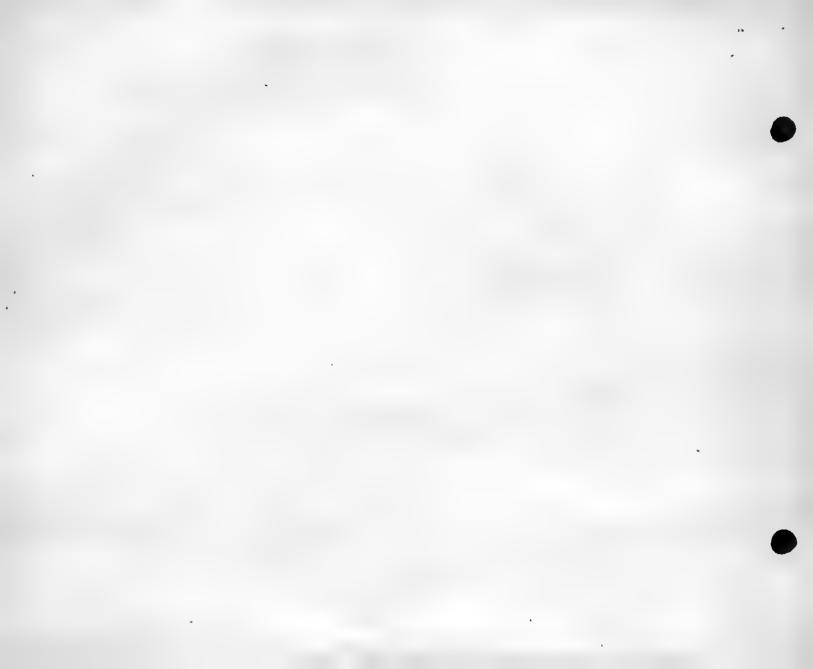


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 69744 09739 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution, Residence before admission) b. COUNTY b CITY OR TOWN (Houtside corporate mils, c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Chevy Chase OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS ON A FARM? Ach Primrose YES NO D NAME OF DECEASED 4. DATE FloRance DEATH B. DATE OF BIRTH IF UNDER 1 YEAR 7. MARRIED AGE (In years Hours -19-03 WIDOWED SC DIVORCED .KUAL OCCUPAT ON (Give kind of work done 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if refired) INDUSTRY housewell 13 FATHER S NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no or Linknown) (If yes give wor or dotes of service) CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(o) PERFORMED? 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) Hour a.m. foctory, street, office bldg., etc.) of work of work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from 4-30, 19-67, to 7-7, 19-67, that (1) (we) lost saw the deceased alive an 6-30 1967, and that death accurred at 5 and from causes and on the date stated above 22a SIGNATURE 22b DATE S GNED MED DIRECTOR 22d ADDRESS 22c PHYSICIAN'S R. H. Sand Strom mo Carroll Ave Totamo Park, Max NAME (Type) 7701 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BUR AL CREMATION 23b. DATE THEREOF zso. RECTO BY REGISTRAR | 2Sb. REGISTRAR'S SIGNATURE Ft. Lincoln Cemetery **ADDRESS** miarles Judge VR A15 (4) 25M 1/67



4	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
E SCA	20740 CERTIFICATI	e of death 69745		
after deoth the funerol ages 1 and s ofter death	PLACE OF DEATH  O. COUNTY MONTGOMERY MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)  o. STATE  b. COUNTY  Maryland.  Montagenery		
urs after y the fu rages 1 surs ofter	b. CITY OR TOWN (If Butside corporate limits, write RURAL and give nearest town)  S. IVEY Spring 4 days	c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)		
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ertificat physici nen ple noval, o	13 FATHERS NAME OLSEN EREDERTISON	14. MOTHER'S MAIDEN NAME UNKNOWN		
death c	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17	M. A. HILLMAN, SON*IN*LAW 38 Columbia Av		
Page 4 may be retained by the hospital or attending physician.  To FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the buriol, tremation, or removal, and in any event, which 72 bours after death.	Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.  (c)    DUE TO   THIDDAIBS Phile			
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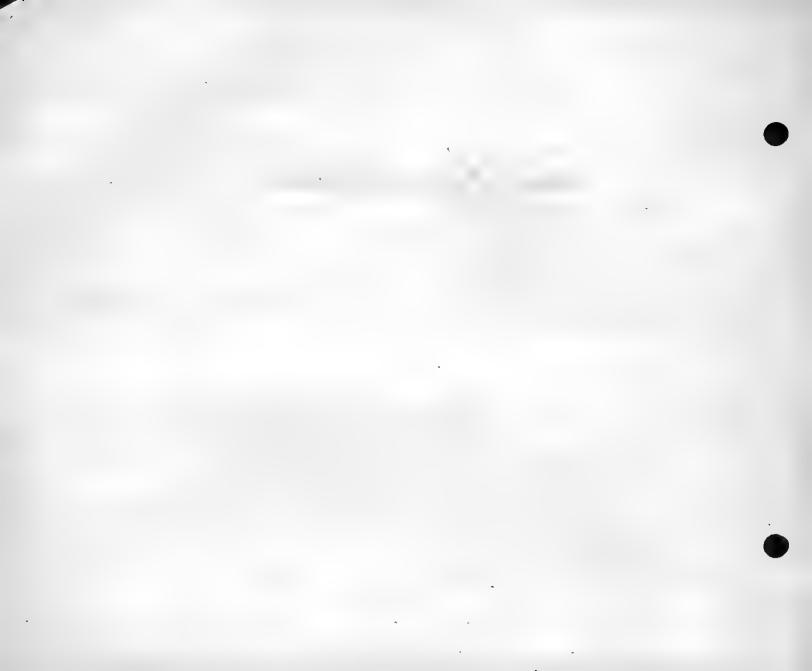
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY INCE GEORGES MARYLAND The law requires that the death certificate be executed within 24 hours after on papers. Pages within 72 hours off b. CITY OR TOWN (If outside/corporate I mits. C LENGTH OF STAY IN 16 (If gutside corporate limits, write RURAL and give nearest town) in by OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) ON A FARM ROANOKE NAME OF corbon Middle Month Dov Year DECEASED OF DEATH remaye corb (Type or print) 19 S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE IF LINDER 24 AR 7. MARRIED 9. AGE (In years lost birthdoy) Months Doys Hours WIDOWED DIVORCED and 100 USUAL OCCUPATION (Give kind of work done ond in 10b KIND OF BUSINESS 11 BIRTHPLACE (County & Stote or foreign country) 12. CIT ZEN OF WHAT physician a ien please during most of working life, even if retired) 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, offending phys WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANI permit. (Yes, no, or unknown) (If yes give wor or dotes of service) signed by the c 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN PART . DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. **DUE TO** Conditions, if ony, which gove (b) rise to immediate couse (a). **DUE TO** for use as the t stoting the underlying couse last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(p) 19 WAS AUTOPS'
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the haspital ar attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burnal transit permit. Then please remare carbon papers. Pages 1 and shauld be filed with the State Dept. at Health prior to burnal, crematian, ar remayal, and in anywherent, within 72 hours after defitible.	20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e P	PLACE OF INJURY (Hame, farm, 20f (City or town) (Co actory, street, affice bldg., etc.)	ounty) (State)
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ATT etair Shar	22a SIGNATURE	ATTENDING AND STACE 226 D	DATE SIGNED
be 1 be 3 be 3 led v	22c PHYSICIANS	M.D PHYS LX DIRECTOR L PHYS. L 40	July 1967
may may ERAL	NAME (Type) Stanley M. Bialek	8218 WISCONSIN Ave. F	setuisan, md
TO HOSPITAL ( Page 4 may b  TO FUNERAL D  director, page shauld be file	23a. BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF 23c NAME OF CEMETERY OF CEMETER	A Cometery Nantu Glo	(County) (State)
•	24 FUNERAL DIRECTOR CLOUBS WILLIAM ADDRESS	Avenue 250. RECD SY RECUSTRAP 250 PROBLEMS	
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours ofter death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. COUNTY o STATE b. COUNTY MARYLAND c LENGTH OF STAY IN 16 guitside cargocate firmits, write RURAL and give nearest tawn) NAME OF HOSP TAL OR INSTITLT ON (If not in haspital, give street odd/ess) d STREET ADDRESS e IS RESIDENCE ON A FARM? completely filled YES within NAME OF serbon First DATE Manth Day DECEASED OF 2 burial, cremation, or removal, and in any event, (Type or print) ario DEATH 196 SEX IF UNDER 1 YEAR 7 MARRIED AGE (In years IF UNDER 24 HRS. 6 COLOR OR RACE DATE OF BIRTH remove Manths last birthday) Doys Hours WIDOWED DIVORCED gud 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during mast of working life, even if retired) INDUSTRY COUNTRY? ottending physicion permit Then pleose rorete ra2 FATHER'S NAME MOTHER'S MAJDEN NAME opoldina arcia WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT (Yes, no. or unknown) (If yes give war ar dates of service) 1B. CAUSE OF DEATH (Enter days and cause per line for (o), (b), and (c).)
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN burial-tronsit ONSET/AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO AUNDICE AND Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to last 19. WAS AUTOPS)
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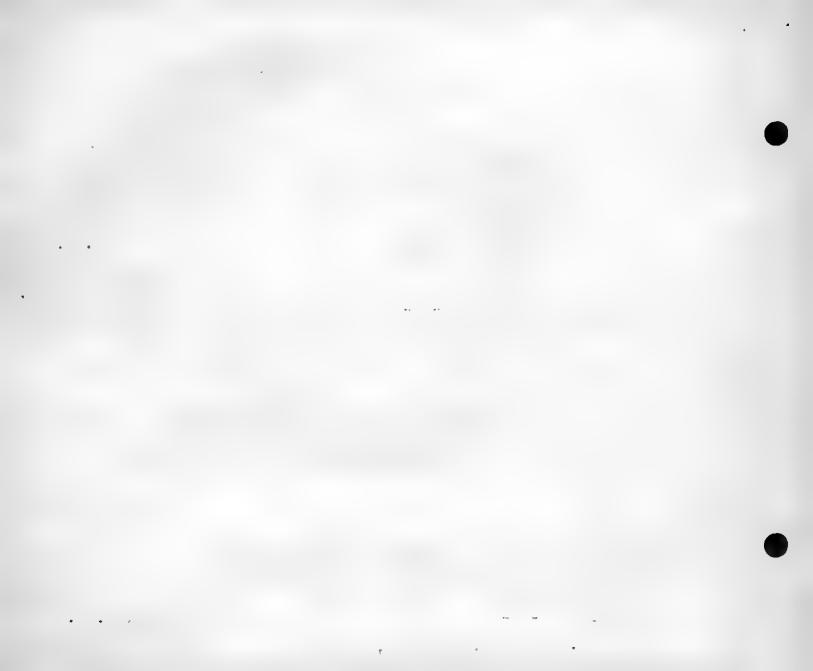
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odmission) o. COUNTY b. COUNTY MARYLAND Montgomerry b. CITY OR TOWN (If outside corporate limits, E. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town) write RURAL and give nearest town) Takoma Park 17 days Rockville bon papers. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS ON A FARM? Washington Sanitarium and Hosnital 11901 Parktong Place NAME OF 4 DATE Month Doy Year DECEASED July 10, (Type or print) DEATH Ruth Coorg campl 5 SEX DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS remove lost birthdov) Months Dovs Hours WIDOWED DIVORCED female white 2-12-01 gud 100 USLAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote or foreign country) physician a nen please during most of working life, even if retired) COUNTRY? Teacher-retired Pennsylvania

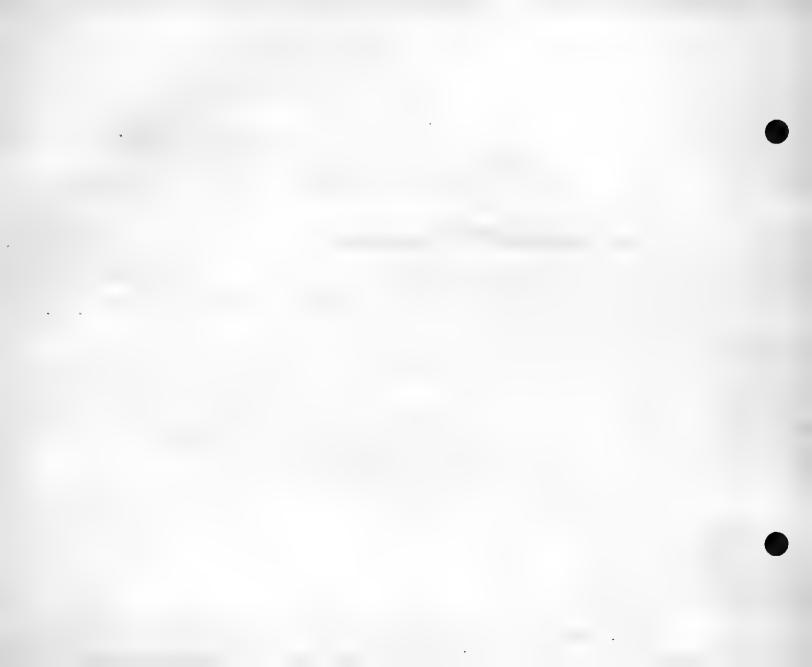
14. MOTHER'S MAIDEN NAME Amarica 13. FATHER'S NAME ar removal, attending phys Charles George Emma Lobr IS WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service Patientle chart 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN al-transit Oroestive IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or attending as the 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 20o ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20c. I.ME OF INJURY Month, Day, Year (Crty or town) (County) (State) Hour o.m. foctory, street, office bldg , etc.) Not While at work at work 21. I certify that (I) (this heapital) attended the deceased from Oct 1962 to July DIRECTOR: / ge 3 shauld 1967, and that death accurred at 1230 AM, fram causes and an the date stated above. saw the deceased alive an\_ 220 SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR directar, page should be filed 22d. ADDRESS 22c PHYSICIAN'S TO FUNERAL NAME (Type) IREY 11161 New Hamashire Silver ORERT 230 BURIAL CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 7-12-67 Mt. Dion Cemetery Jenner. Penna. 24. FUNERAL DIRECTOR 250 REC D BY REGISTRAR VR A15 (4) PUMPHREY. Bethesda, Maryland 25M 1/67



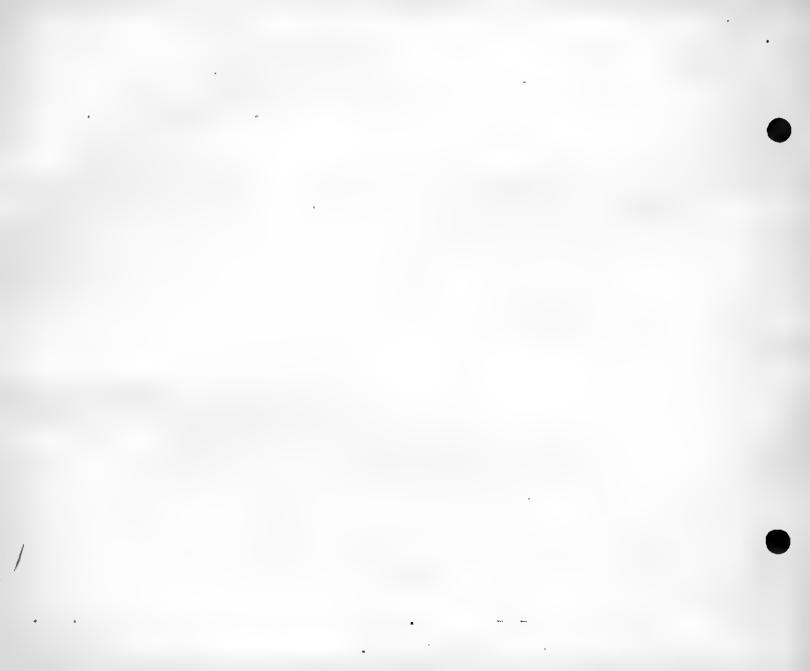
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09745 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY MARYLAND b CITY OR TOWN (if outside comparate imits C LENGTH OF STAY IN 16 **CITY OR TOWN** purside corporate limits, write RURAL and give nearest town) 30 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 8809 Kensington Parkway YES NO [ 3. NAME OF DECEASED Middle 4. DATE Day Year We You McChesney (Type or pnnt) DEATH 196 s sex 6. COLOR OR RACE AGE 7 MARRIED NEVER MARRIED DATE OF BIRTH n years Bast birthdoy) Months 27, 1886 and in any WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 13 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland Retired Secretary 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME James Gilliland Alice McChesney 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Sister Same as Item 2. (Yes, no, or unknown) (If yes give war or dates of service) ь Mary Elizabeth Gilliland 578-01-0772 No 18. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c).
PART L DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gave ase to immediate couse (a), DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO YES 20a ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (Eity or town) (Stote) 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED (County) factory, street, office bldg , etc.) 21. I certify that (1) (this haspital) attended the deceased fram... , 1966, to \_\_\_\_\_\_, that (1) (we) lost O HOSPITAL OR ATTEND Page 4 may be retained 1967, and that death occurred at 52 M, from causes and an the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an 220 SIGNATURE MED DIRECTOR M.D. PHYS otru BAYSICIAN'S 22d ADDRESS NAME (Type) 23b DATE THEREOF 230 BURIAL CREMATION 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) BENOVAL (Specify) 7-11-67 Rock Creek Cemetery Washington, D. C. 24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Robert A. Pumphrey, Bethesda, Maryland DATE J Charles



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 08751 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY MONTOGIME MARYLAND Pages 1 urs after b CITY OR TOWN (If outside/corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ON A FARM? 140m YES NAME OF DATE Year DECEASED OF (Type or print) DEATH SEX 6. COLOR OR RACE 9. AGE (In years 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH last birthdoy) Months Days Hours WIDOWED DIVORCED 100 JSUAL OCCUPAT ON (Give kind of workidone during most of working life, even if retired)/ 100 B MDUSTRY 10ba KIND OF BUSINESS OR 12 CITIZEN OF WHAT and In Own home COUNTRY? MINKIDOLY 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME crematian, or remayal. Saviors Dave Wilson 200000000000000 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address 126 Normandy Drive (Yes, no, or unknown) (If yes give war or dates of service Mary Louise Brown CAUSE OF DEATH (Enter only one couse per-line for (a), (b), and (c) NTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE TO Selecosis Conditions, if any, which gave rise to immediate couse (a), Multiple stoting the underlying couse hrombises last 19. WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/6 erro sclerosis 20o ACCIDENT WAS UNDERLYING IT 20b DESCRIBE HOW INJURY OCCURRED (Enter ridgure of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED TIME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home, farm (City or fown) (County) (State) Not While Hour om. foctory, street, office bldg etc.) at work of work 21. I certify that (I) (this hospital) attended the deceased from 10 1953 to 144 22, 196/, that (1) (we) lost \_\_\_\_1962, and that death occurred at ? Z M-fram causes and an the date stated above saw the deceased alive on tech 220 SIGNATURE M.D 22d. ADDRESS 22c. PHYSICIAN S 10620 NAME (Type) 00 Silver NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. 23b. DATE THEREOU (County) Parklawn Cemetery July 25. Rockville. Maryland Pumphrey. Inc.

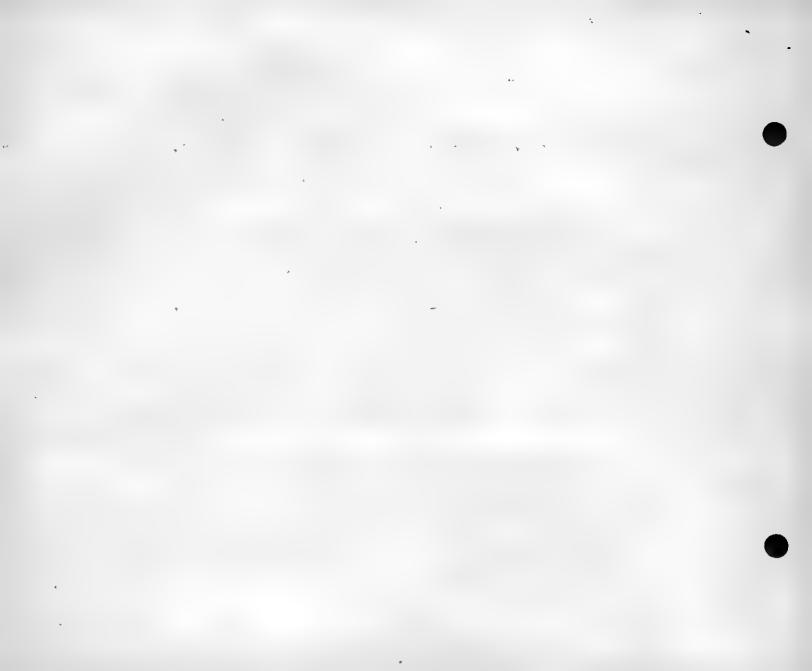


- 12-1-11/	Items 18-21 Film 391 8-3MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
FOR STATE	09747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03752							
HEALTH DERT.	PLACE OF DEATH  o. COUNTY Montgomery  MARYLAND  2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission)  o. STATE Maryland b COUNTY Montgomery							
y de ay y, ond 3 PM3. Pg	o CTY OR TOWN (If outside carporate mits write RURAL and give nearest town)  Ol nev  CENGTH OF STAY IN 1b  C CITY OR TOWN (If outside carporate mits, write RURAL and give nearest town)  Rt. 2, Gaithersburg, Md.							
form of Depo	Olney  d NAME OF HOSPITAT OR INSTITUTION (If not in hospital, give street oddress)  Montgomery General Hospital  Olney  d Street ADDRESS  d Street ADDRESS  ves \( \sigma \) NA FARM?  ves \( \sigma \) NO \( \sigma \)							
offer death. If say de of Give Peges 1, 2, and played with the State Departmen.	3 NAME OF First Middle Lost 4 DATE Month Doy Year OF OF 7 20 19 67  S SEX 6 CO.OR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS							
office blog	Male White WIDOWED DIVORCED   6/25/38 29 birthday) Months Doys Hours Min.							
d within 24 hours offer death. If in pencil in Item 18 Give Pages Examiner's Office ploagurith for File pages Lond 2 with the State. 72 hours after death.	IDD US_ALOCCUPATION (Give kind of work done during most of working life, even if retired)   IDD KIND OF BUSINESS OR   II BIRTHP.ACE (State or foreign country)   I2 (TZEN OF WHAT COUNTRY? INDUSTRY   Industry   Industry   Industry   Industry   Industry   Industry   Identification   Identificati							
d withi in pend Exami Exami File po 2 hours	Floyd Goad Anna Kahl  IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address							
xecute ding" ledicol perm.t	(Ves, no, or unknown) (If yes give wor or dofes of service) 220-34-4301 Wife, Betty Goad, Gaithersburg, Fld.  18 CAUSE OF DEATH (Enter only one cause per ne for (o), (b), and (c))							
INER: This certificate should be executed within 24 hours ofter death e certificate, writing the word "pending" in pencil in Item 18, Give Page should be forworded to the Chief Medicol Examiner's Office bloggraph files.  3 should be used as a burial-transit perm.t File pages land 2 with the Statition, or removal, and in any event within 72 hours after death.	PART I. DEATH WAS CAUSED BY  IMMEDIATE (AUSE (o) Multiple extreme injuries including  Conditions, if ony, which gove isse to immediate cause (o), stating the underlying cause lost  (c)  Multiple extreme injuries including  ONSET AND DEATH							
INER: This certificate, writing should be forword files. 3 should be used from the control of th	PART I OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(a)  19 WAS AUTOPSY PERFORMED? YES NO  20b DESCRIBE HOW INJURY OCCURRED (Enter noture of njury in Port Lor Port Lor Port Lor Rot Lor Not Lo							
INER: 1 e certific shauld b files. 3 should ion, or r	PERFORMED?  YES X NO  2Do EXTERNAL CAUSE WAS PRIMARY XD or CONTRIBUTING CALL CALL CONTRIBUTING CALL CALL CALL CALL CALL CALL CALL CAL							
	21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinio							
O DEPUTY MEDICAL EXAM necessory, please execute the the funeral director Page 4 5 may be retained far your O FUNERAL DIRECTOR: Page Health pr or to buriol, cremo	death resulted from Natural causes Accident of, Suic de , Hamicide , Undetermined manner   ACTUAL SIGNATURE SIGNATURE ASSISTANT MEDICAL EXAMINER   22. DATE SIGNED							
O DEPUTY necessory, the funeral 5 may be 0 FUNERAL Health pr o	EXAMINER'S BELDEN R. NEAP 4, D. Abdross Strength William or county) 7/21/1967							
0	REMOVAL (Specify)  Burlal  7-24-67  Mt. Tabor  Etchison Mont. Md.  24 FUNERAL DIRECTOR  ADDRESS  250 RECD BY REGISTRAR 2.56 REGISTRAR 2.50 REGISTRAR 3.50 NATURE							
VR A15ME (5)	Francis H. Barber Laytonsville, Md. DATE JUL 2 5 1967 fcliantes Jusque							

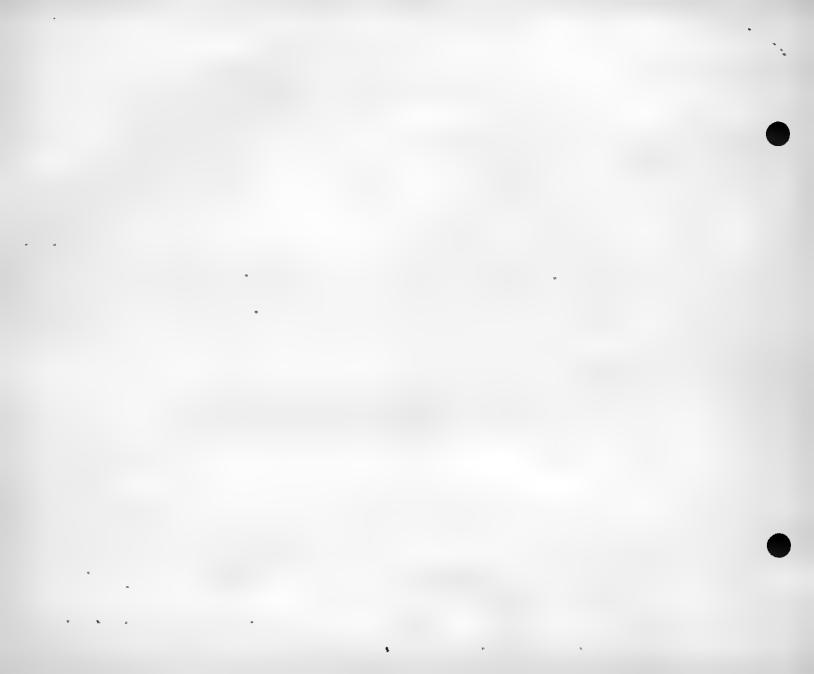


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09753 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. COUNTY b COUNTY MONT GOME RY MARYLAND MONTGOMERY MARYLAND b. CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY IN 1h c. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest tawn) write RURAL and give nearest town) 13 DAYS ROCKVILLE OLNEY d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ,⊆ d. STREET ADDRESS B. IS RESIDENCE ON A FARM? filled i 16 THOMAS ST. MONTGOMERY GENERAL HOSPITAL NO 🗍 3. NAME OF First 4. DATE Lasi Month Dov Year completely DECEASED 19 67 26 DOROTHY SAVIERS (Type or print) GONZALEZ 0 DEATH S SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last burthday) Haurs FEMA LE WHITE 7-31-97 and in any WIDOWED DIVORCED puo 10a USUA, OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? USA during most of working tife, even if retired) SERVICE INDIANA RETIRED 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, JENNIE HOADLEY GEORGE SAVIERS offending popermit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, na, or unknown) (If yes give war ar dates of service) Address 315-18-7997 MEDICAL RECORD DEPT. cremotion, IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c),
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO buriol, Coronary Conditions, if ony, which gave rise to immediate cause (a), **DUE TO** stating the underlying couse by the hospital or attending been Ф 00 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 110 WAS AUTOPS) PERFORMED? has CATION be detached for use State Dept. of Health YES [V] NO certificate 20a. ACCIDENT WAS JNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20t TIME OF INIJRY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (State) (actory, street, affice bldg., etc.) Not While After at wark 1966 to 140 26, 1962, that (1) (we) lost 21. I certify that (1) (this hospital) attended the deceased from.... Page 4 moy be retained D FUNERAL DIRECTOR: A 1: 10Am, from causes and an the date stated above ruling 5 19 67, and that death accurred at saw the deceased alive on. 22a SIGNATURE 22b. DATE SIGNED X director, page 3 should be filed v DIRECTOR PHYS PHYS 22c. PHYSICIAN'S 22d, ADDRESS O HOSPITAL NAME (Type) FREDERICK MOOMAU. M. D. MEDICAL CENTER, SANDY SPRING, MD. 23a BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) ((ounty) Cedar Hill Prince George Co., Md. Cremation 24 FUNERAL DIRECTOR

Tyson \*heeler Funeral Home-1331 Rockville Pike DATE VR A15 (4) Rockville Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 09749 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed, if institution Residence before admission) o. COUNTY b. COUNTY Montgomery o. STATE Mary land tely filled in by the function papers. Pages 1 c MARYLAND b CITY OR TOWN (if outside corporate mits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? 7524 Hampden Lane NO K YES and completely f NAME OF 4 DATE Month Lost Year DECEASED (Type or pant) Scodwin DEATH 1967 S SEX 8 DATE OF BIRTH 9. AGE (in years F UNDER 1 YEAR **IF UNDER 24 HRS** 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months Hours WIDOWED DIVORCED 13-26-89 Oa USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) COUNTRY? U. during most of working life, even if retired) signed by the attending physician obviral-transit permit. Then please burial, crematian, ar remaval, AMB is Maine Housewife
13. FATHER'S NAME S. 14. MOTHER'S MAIDEN NAME Edward P. Dore Sarah F. Patten 17. INFORMANT Daughter 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service Item 2. Same as Virginia G. Rolnick 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY ONSET AND DEATH curdio- respiratory Faulure TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may baretaned by the haspital ar attending physician DUE TO Conditions, if any, which gove 1 ar curound tous 10 6 mas rise to immediate couse (a), DUE TO stating the underlying cause **IO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar ta WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES 🗌 NO X 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18.) 20g ACCIDENT WAS UNDERLYING . OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20c. T.ME OF INJURY Month, Doy, Year Hour o.m. 2Dd INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) While Not While at work foctory, street, office bldg, etc.) 2). I certify that (1) (this haspital) attended the deceased fram , 1957, to 29504, 1967, that (1) (we) last saw the deceased alive an 28.5 000, and that death accurred at 428 M, fram causes and an the date stated above. 22o, SIGNATURE 22b. DATE SIGNED M D 7801 Norfolk Ave. 22c PHYSICIAN'S 22d. ADDRESS JOHN M. WYMAN NAME (Type)/ Bethesda. Md. 230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) ((county) (State) Burial Specify) 8-2-67 XXXX Oak Hill Cem. Washington, D: ADDRESS 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 sthanken ynoge Pumphrey. Bethesda, Maryland



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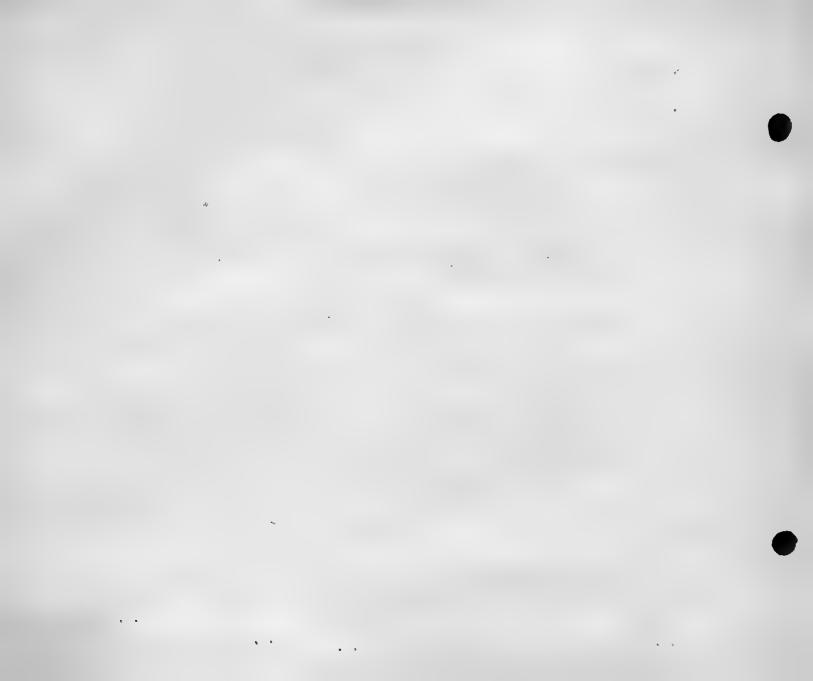
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VR A15 (4) 15M 9/60



1_	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE 1, MARYLAND
	CO754 CERTIFICATE OF DEATH
funeral	1. PLACE OF DEATH  2. USUAL RESIDENCE (Where decaesed I ved, If Institution; Rasidanca before edmiss on)
* 12 ft	a. COUNTY MONTGOMENY MARYLAND 6. STATE Md. 6. COUNTY MONTGOMENY.
	b CITY OR TOWN (if outside corporate limits, write RURAL end give nigrest town)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If outside corporate 1 mits, write RURAL end give nigrest town)
	Tukoma Pauk lakoma Kurk
3.00.0	d NAME OF HOSPITAD OR INSTITUTION (if not in hospital, give street eddrass)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?  VEC AUC.  VEC AUC.
etely f pers. F 72 hou	3. NAME OF First Models Last 4. DATE Month Dey Year
pape 72	DECEASED (Type or print) Fffie Columbia Green DEATH July 24 1967
con ithin	5. SEX   6. COLOR OR RACE 7. MARRIED   NEVER MARRIED   8. DATE OF BRTH   19. AGE (in years IN UNDER 1 YEAR IF UNDER 24 HRS
and carb	WIDOWED DIVORCED 11/29 77 last birthday Months Days Hours Min.
Cian Cian Over Over Over Over Over Over Over Over	the. USUAL OCCUPATION (Give kind of work done during most of working life, even if retirad) 106 KIND OF BUSINESS OR INDUSTRY 11 B RTHPEACE (County & State, or fore gn country) 12 CITIZEN OF WHAT COUNTRY?
hysin hysin remy any	miresewate District of Columbia Visi
ng p	13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME  Boukley.
andii andii	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address  Address
a affe The oval,	(Yas, no, or unkown) (Hyasgivawerordatasofservica) 218-54-6466. 144 Green III Lee Are. Park, md.
s tha an. y tho mit. rem.	18. CAUSE OF DEATH [Enter only one couse par I ne for (a), (b), and (c) ]
ysici ysici par par	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conquestive heart facture 2-3 day
red ar ph arign ation	DUE TO
ading seen seen sal-tre reme	Conditions, if eny, which (b) Antonio Scleretic Caudio yus culor 15 yes, gave rise to immediate course
alter alter	(a), stating the underlying DUE TO
the buri	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINALPDISEASE CONDITION GIVEN IN PART 1(e), 19, WAS AUTOPSY
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a hoy cer or us pric	206. ACCIDENT WAS UNDERLYING ☐ 206. DESCR BE HOW INJURY OCCURED, IEnter nature of injury in Part for Part II of Item 18 0 OR CONTRIBUTING ☐ CAUSE OF DEATH  GIFT EITHER, NOTIFY MEDICAL EXAMINER!
and for the self-free self	
Affer	Hour e.m. Wh.la Not Wh.la factory, street, office bldg , atc.)
pt. o	21.   certify that (I) (this hespital) attended the deceased from
2 D 4 B B B B B B B B B B B B B B B B B B	saw the deceased alive on 19.12., and that death occurred at
IRE Shou	22a. SIGNATURE ATTENDING MED. STAFF SIGNED
147° 5	holin D. Die welch M.D. PHYS. DIRECTOR PHYS.
ERA Bage With	PHYSICIAN'S NAME (Typa) John D. Guswell mp 4830 "V"ST n.w. DC:
d cor.	230. BURIAL, CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete)
2 g G g g	REMOVAL (Specify)
YR A15 (4)	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR'S SIGNATURE
15M 9/60	DATE JUL 60 1961 fredrikes fringe

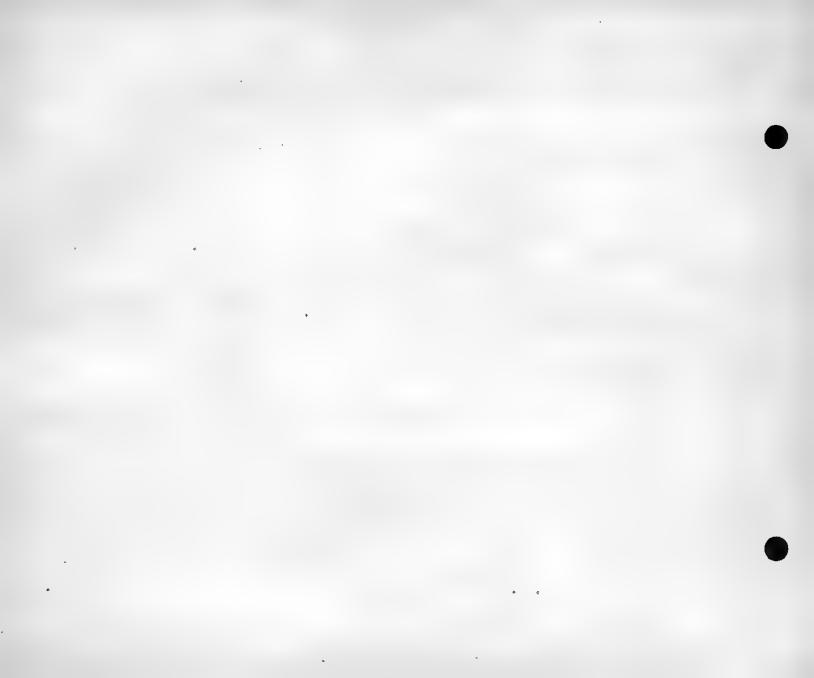
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE filled in by the fund papers. Pages 1 c thin 72 hours after d Montgomery Montgomery County MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (It outside corporate limits, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours aft c EITY OR TOWN (If outside corporate limits, write RURAL and give peacest town) write RURAL and give nearest town) days e IS RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13431 Doncaster Drive Montgomery General Hospital NO K completely fi NAME OF First Middle Lost 4. DATE evgant wit Month Year DECEASED 25th 67 July Katie Alameda Gregory (Type or print) DEATH 9 AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED TOX 8 DATE OF BIRTH remove ( **NEVER MARRIED** birthdoy) Months Dovs Hours or removal, and in any White WIDOWED DIVORCED Female puo 10a USUA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) please U.S.A. physician c nen please during most of working life, even if retired) **INDUSTRY** N.C. Housewite Own home 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Kathleen Mitchell Henry Potter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) Doncaster D cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit burial, cremati PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (0) DUE TO ex wet aprises Conditions, if any, which gove rise to immediate couse (a), **DUE TO** r this certificate has been si detached for use as the b te Diipt of Health prior to b stoling the underlying couse be retained by the hospital or attending 19 WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO D CERTIFICA 200 ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of fem IB.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form (City or town) 20c. TIME OF INJRY Month, Doy, Year 20d INJURY OCCURRED ((ounty) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While After of work 21. I certify that (I) (this haspital) attended the deceased fram\_\_\_ 1967 to 1947, and that death accurred at 2:57 PM, from causes and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an 22o, SIGNATURE 22b. DATE SIGNED STAFF July 25. 1967 DIRECTOR director, page 3 M.D. O HOSPITAL Poge 4 moy b 22c. PHYSICIAN'S 22d ADDRESS NAME (Type) Medical Center. Sandy Spring. Md. Dement DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 8 JRIAL CREMATION (Stote) Goshen Baptist Church 250. REC D BY REGISTRAR VR A15 (4)

25M 1/67

Puxphrey

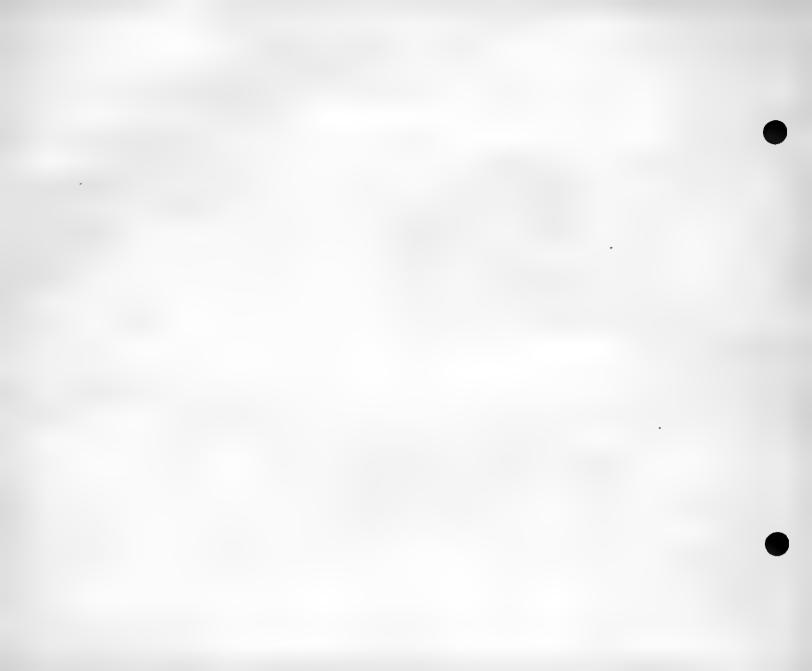


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 63758 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY O STATE MARYLAND MONTGOMERY b COUNTY MONTGOMERY MARYLAND b CITY OR TOWN (If outside carparate limits, write RURAL and give percent town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) BETHESDA d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 4903 BATTERY LANE SUBURBAN NAME OF Middle 4 DATE Last Month Dov Year DECEASED JULY JOHN GREGORY PINTER DEATH IF UNDER 1 YEAR S. SEX IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years 7 MARRIED psi birthday) Man 1/9/1890 WHITE WIDOWED DIVORCED MALE 10a LSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life (even if retired) GREECE 14. MOTHER'S MAIDEN NAME **AMANDA** JOHN GREGORY WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give war at dates of service) WIFE, ANNA GREGORY( SAME AS ABOVE) NO INTERVAL BETWEEN 1B CAUSE OF DEATH (Enter only one couse per line PART 1 DEATH WAS CAUSED BY ONSET AND DIATE IMMEDIATE CAUSE (a) DHE TO Conditions, if any, which gave use to immediate cause (a), DUE TO stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT DELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS 20b DESCRIBE HOW INJURY OCCURATED (Enternature of injury in Port I or Port II of item 18) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) factory, street, office bldg. etc.) 21. I certify that (I) (this hospital) attended the deceased from 10 /2 , 1966, to July 29 , 1967, that (I) (we) las saw the deceased give an July 29 1967, and that death accurred at 255 M, frag causes and an the date stated above 22g SIGNATURE 226. DATE SIGNED DIRECTOR NAME (Type) ALLEN J. O'NETLL O FUNERAL 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. ŁOCATION (City or Town) 230 BURIAL, CREMATION, (Yinuo)) (Stote) REMOVAL (Specify) Parklawn Cemeterv Rockville, Maryland 8-1-67 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR PUMPHREY, Bethesda, Maryland 1967

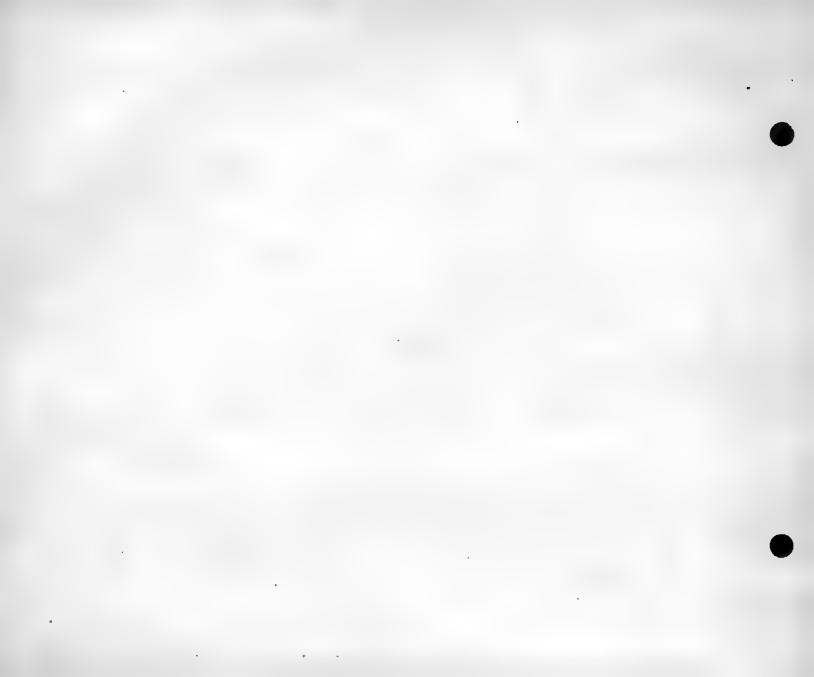


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item h The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH attending physician and campletely filled in by the funera permit. Then please remove-carban papers. Pages 1 and an, ar removal, and in any event, within 72 hours after deal o. COUNTY o STATE 5 COUNTY MARYLAND Maryland Montgomery Montcomery b ( TY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give negrest town) Silver Spring Wheaton mos. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS YES NO X University Nursing Home 11711 Love joy\_St. 3 NAME OF First Middle 4 DATE Manth Lost Dov Year DECEASED July event, 19 67 (Type or print) Griffin DEATH tillian Ethel S. SFX AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS B. DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Months Hours WIDOWED 12/1/1882 burial, crematian, ar removal, and ın any DIVORCED White Female 12 CITIZEN OF WHAT 10a USUA, OCC. PATION (Give kind of work dane during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) **COUNTRY?** omo Housewife Louisville, Kentucky 14. MOTHER'S MAIDEN NAME (UNKNOWN) LISA 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give war or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 11711 Love My Street Mrs. Dee Wender-Silver Spring. Md. no none INTERVAL BETWEEN ONSET AND DEATH 1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p IMMEDIATE CAUSE (a) 1, 1, 7, 4 Page 4 may be retained by the haspital ar attending physician. DHF TO Conditions, if ony, which gave nse ta immediate couse (o). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept of Health prior ta WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIES MEDICAL EXAMINER) 205. DESCRIBE HOW INJURY-OCCURRED. (Enter nature of injury in Port of Port II of item 18.) director, gage 3 shauld be detache shauld be filed with the State Dept 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home-form, (City or town) (County) (Stote) factory, street, office bidg, etc.) Nat White OR ATTENDING -af wark at wark 21. I certify that (1) (this haspital) attended the deceased fram Acad 1967, that (I) (we) last 19 47, and that death accurred at / M, fram causes and an the date stated above. saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN S University Blvd., West NAME (Type) Bufalino, Russell Silver Spring Md. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23a BUR AL, CREMATION, DATE THEREOF REDOVAL (Specify) BINMINGham MWOOD . CEM. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

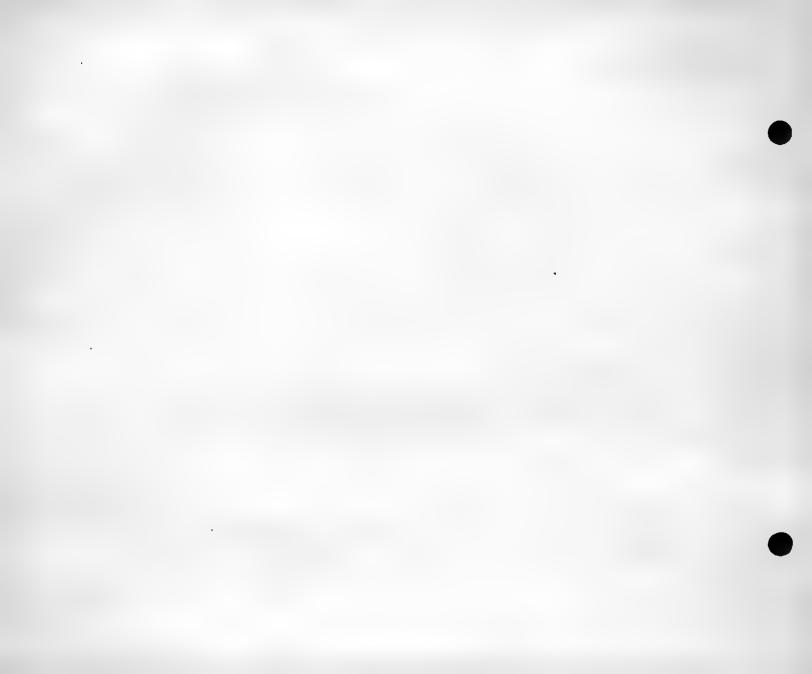




MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTY o. STATE . n **b.** COUNTY ONTGOMEVY MARYLAND c LENGTH OF STAY IN 16 autside carparate limits, write RURAL and give nearest town b CITY OR TOWN (If outside corporate limits popers. Pag write RJRAL and give nearest\_lown a TT SUI d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO FA corpon 3 NAME OF Middle 4. DATE Day 1DeY DECEASED OF 22 aac 19 6 (Type or print) DEATH IF UNDER 1 YEAR S. SEX 9 AGE ( n years JE UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Months last birthday) Hours whIT-e 22 1967 DIVORCED WIDOWED 3 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY Maryland - Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME USSell everl 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) Alt yes give war or dates of service as about INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH burial-tronsit PART I. DEATH WAS CAUSED BY: Prematurit IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying cause by the hospital or offending O FUNERAL DIRECTOR: After this certificate has been as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO DO YES þ 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF OFATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bidg., etc.) of work at wark 2). I certify that (1) (this hespital) attended the deceased fram July 22, 19 67, ta July 22, 19 67 that (1) (we) last saw the deceased alive an July 22 19 67, and that death accurred at 4:200 M, fram causes and an the date stated above 22b. DATE SIGNED 22a, SIGNATURE 24-67 DIRECTOR M.O. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 105 SPRING ST. SILVER SPRING 23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) 23a. BURIAL, CREMATION Burkal (Specify) "eaven demetery Md. Silver Spring Montg. Gate of 109831 Rockville Picket BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Tyson Wheeler Funeral Home DATE JUL 3 1 1967 Rockville, Md. 20 M 1/66



	STATE DEPARTMENT OF HEALTH CORDS, 301 W. PRESTON STREET, BALTIMORE, M	ARYLAND 21201
	TIFICATE OF DEATH	09762
	ARYLAND Maryland	institution. Residence before admission) b. COUNTY  Montgomery
b CITY OR TOWN (f outside corporate limits, write SURAL one give nearest town)  CCK VIIVE	1. Rockville	rite RURAL and give nearest flown)
d NAME OF MOSPITAL OR INSTITUTION (If not in hospital, give street Modress)	d. STREET ADDRESS 734 Carr Ave	e IS RESIDENCE ON A FARM? YES NO
3 NAME OF DECEASED (Type or pnnt) GIRAYS &	Haller DEATH Ju	Month Doy Year 1967
S SEX 6 COLOR OR RACE 7. MARRIED NEVER MAR WIDOWED DIVO	RCED 1-14-10 ST	day) Months Days Hours Min
100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  105 KIND OF BUSINESS O INDUSTRY  2 CSS S	hop Pennsylvania	Y) 12. CITIZEN OF WHAT COUNTRY? USA
John & Shull	14. MOTHER'S MAIDEN NAME FLOCEN CE F	EFFER
(Yes, no, or unknown) (If yes give wor or dotes of service)  16 SOCIAL SECURITY N  187-16 44	802 Husband - 734 Ca	
18. CAUSE OF DEATH (Enter only one cause per fine for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	occ lusion	INTERVAL BETWEEN AND DEATHIL
Conditions, if any, which gave rise to immediate cause (a).		
stoting the underlying couse (c)  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT	DELATED TO THE TEDAHNAL DISCASS COMPLICION CHURN IN DADY	VZQOTIJA SAW 017
206 ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJUR	Y OCCURRED. (Enter noture of injury in Port 1 or Port II of item	PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
p.m. 17 of work L of work L	foctory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the decease saw the deceased alive an	ed from Jan 17, 1967 to Ju, and that death accurred at 125 AM, from co	suses and an the date stated above.
22c PHYSICIANS NAME (Type)	M.D. ATTENDING MED DIRECTOR PHYS.  22d. ADDRESS	7-28-67
	EMETERY OR CREMATORY 23d OCATION (City	y or Town) (County) (State)
Durial 13167 AUDRESS	250 RECD BY REGISTRAR 2	Swille Monty. The



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09758 CERTIFICATE OF DEATH

67.2							
D 2-5	PLACE OF DEATH		2. USUAL RESIDENCE (Whe	ere deceosed lived, if institution	n. Residence before admission), /		
137	L D. COUNTY				b. COUNTY		
<b>Yei / -</b>	Yontgomery	MARYLAND	Maryland	Prince Ge	orge		
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 16	c. CITY OR TOWN (If outsice	de corporate imits, write RURA	L ond give neorest town)		
3. 5	Takoma Park	3 davs	Hvattsville		* /		
	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give	street oddress)	d STREET ADDRESS		I e IS RESIDENCE		
					e IS RESIDENCE ON A FARM?		
	Jashington Sanitarium and Ho		7101 New Ha	mpshire avenu	YES NO w		
3.	NAME OF First	Middle	Lost 4	. DATE Month	Doy Year		
	DECEASED (Type or print) Andrew	Jackson Ha	rrison	DEATH JUST 26	19 67		
5.	SEX 6 COLOR OR RACE 7. MARRIED	NEVER MARRIED   8	DATE OF BIRTH	9. AGE (In years	IF UNDER I YEAR   IF JNDER 24 HRS		
	4-24			lost birthdoy)	Months Doys Hours Min		
	TIAL A WILL VE	DIVORCED [	8-25-92	1 LL Y15			
10	o JSUAL OCCUPATION (Give kind of work done 10b. KIND ( ring most af warking life, even if refired) (NDUS)	OF BUSINESS OR	11. BIRTHPLACE (County & St	tote, or foreign country)	12 CITIZEN OF WHAT COUNTRY?		
00		na Admin	Maryland		America		
13	FATHER'S NAME	T	14. MOTHER'S MAIDEN NAM	N.F.	1111011101		
	Indrew Jackson Harrison		Rose Eag	· · · · · · · · · · · · · · · · · · ·			
15	was deceased ever in u.s. armed forces? 16 SOCIA es, no, or unknown) (If yes give wor ar dates of service)	AL SECURITY NO 17 IN	FORMANT 1/2 1/0	RRISON Address			
1,	Ves U.S.Army VIII 216-	-46-9108 Pe	MARY/K. HA	William II	SAME AS 12		
-			U.C.	· ·	INTERVAL BETWEEN		
	18. CAUSE OF DEATH (Enter on y one couse per line for (o), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	(0), one (4),	11.		ONSET AND DEATH		
		Arlm			3 marith		
	1/361 DUE TO	, .		you and a	/ _/		
	Condit ons, if any, which gave (b)	grane fl	renderly the	Certity,	6 parenta-		
	rise to immediate couse (a), stating the underlying couse DUE TO		7				
	lost. (c)		/				
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DI	CATU BUT NOT BELATED TO TH	IT TERMINAL DISTAGE CONDIT	TION ORDER IN SURT II I	19 WAS AUTOPSY		
~	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE	EATH BUT NOT KELATED TO TE	IE IEKMINAL DISEASE CONDIT	TION GIVEN IN PART 1(0)	PERFORMED?		
ICATION	unemore. later	negelesti	heart all	real	YES NO 🕢		
44.	200 ACCIDENT WAS UNDERLYING ☐ 20b DESCRI	BE HOW INJURY OCCURRED (E	nter noture of injury in Port	or Port II of Item 18)			
CER1	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
MEDICAL		Y OCCURRED T 20e PLACE	OF INJURY (Home, form,	20f (City or town)	(County) (State)		
	Hour o.m. While -		ry, street, office bldg., etc.)	zai (cr i oi iowii)	(coon4) (3046)		
2	p.m. 17 of work L.	3 01 MOIK 1-3					
	21. I certify that (!) (the hospital) attended saw the deceased alive an 7-26	the deceased fram 2	- 10 - 195	7. to 7-26	. 1967, that (1) Iwel las		
	saw the deceased alive an 7-26	19 6 Z, and that	death accurred at//	IC F.M. fram causes an	ed on the date stated above		
	22o. SIGNATURE	/			22b. DATE SIGNED		
	Lineach T K. Jul	// 110	ATTENDING ME	D STAFF PHYS			
	as providence	L, M.D		ECTOR L PHYS L	7-27-67.		
	22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	0 0.1	C . M.		
L	NAME (Type) Seruch 7. Kimble		1927 Pershi	na Dr., Silve	a opring, Md.		
23	o. BURIAL, CREMATION, 23b DATE THEREOF 2	3c. NAME OF CEMETERY OR C	REMATORY	23d LOCATION (City or Town	) (County) (Stote)		
)	REMOVALISPOSITY) REMOVALISPOSITY) REMOVALISPOSITY)	Non Cath I	Const	0-1+: (4)			
7	4. FUNERAL DIRECTOR.	New Cathedral	2So. REC'D BY	Raltimore Ma	STRÁR'S SIGNATURE		
1	on Brector homogeness Shows 8434	Georgia Hugys	AHI		Charle . Verde		

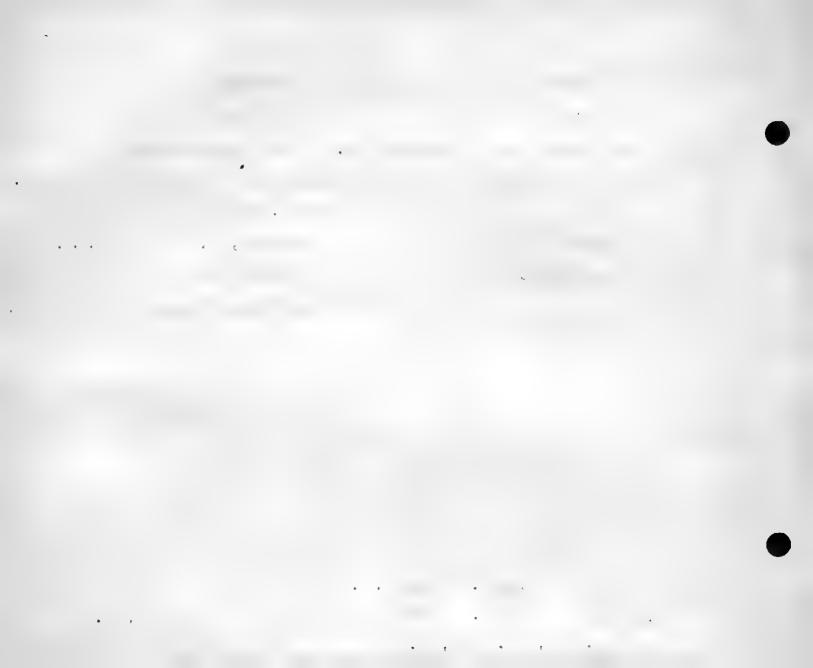
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09759 09764 CERTIFICATE OF DEATH low requires that the death certificate be executed within 24 haurs after death. deoth puo 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before odmission)
o. STATE
Maryland
b. COUNTY Frederick funerol PLACE OF DEATH a. COUNTY Montgomery s offer MARYLAND b (ITY OR TOWN (If outside corporate limits, write RURAL and gone nearest town)
Bethesda c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 DOA Mount Airy d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? The Clinical Center, Bethesda, Maryland Route #3 YES NO X 3 NAME OF First Lost 4. DATE Month remove carbon! Doy Year DECEASED (Type or print) Jerry Wayne Hartman July burial, crematian, or remayol, and in any event, DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS 9 AGE (In years S SEX 6. COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH 7. MARRIED lost birthdoy) Months Hours White Male WIDOWED DIVORCED 22 December puo IDo JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY ? during most of working life, even if retired) INDUSTRY ottending physicion permit. Then pleose Maryland Student IISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Shirley L. Mullinix Harvey E. Hartman 17 INFORMANTThe Medical Records 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dates of service) The Clinical Center, Bethesda, Maryland None 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY-INTERVAL BETWEEN signed by the bur of-tronsit p ONSET AND DEATH Acute Lymphatic Leukemia IMMEDIATE CAUSE (o). DUE TO Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO stoting the underlying couse to Hospital OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the hospitol or attending director, page 3 should be detoched for use as the shauld be filed with the State Dept. af Health prior to 19 WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) ΝO YES TX certificote 2Do ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (County) 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (State) TO FUNERAL DIRECTOR: After this 2Dc. TIME OF INJURY Month, Doy, Year Not While factory, street, office bldg, etc.) While of work 2). I certify that (4) (this haspital) attended the deceased fram (DOA) 29 July 67, to 29 July 19 67 that (3) (we) last sow the deceased alive on (DOA) 29 July 67, and that death accurred at 3:30 M, from causes and on the date stated above. 22a SIGNATUR 22b DATE SIGNED STAFF PHYS. X 29 July 1967 DIRECTOR 22d ADDRESS The Clinical Center, National PHYSICIAN'S NAME (Type Robert C. Young, M.D. Institutes of Health, Bethesda, Md. 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREO! 230 BUR AL, CREMAT ON REMOVAL (Specify) Poplar Springs, Md. Poplar Springs Meth. 250 REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) Olin L. Molesworth, Damascus, Md. marles judge

. . . . . . .

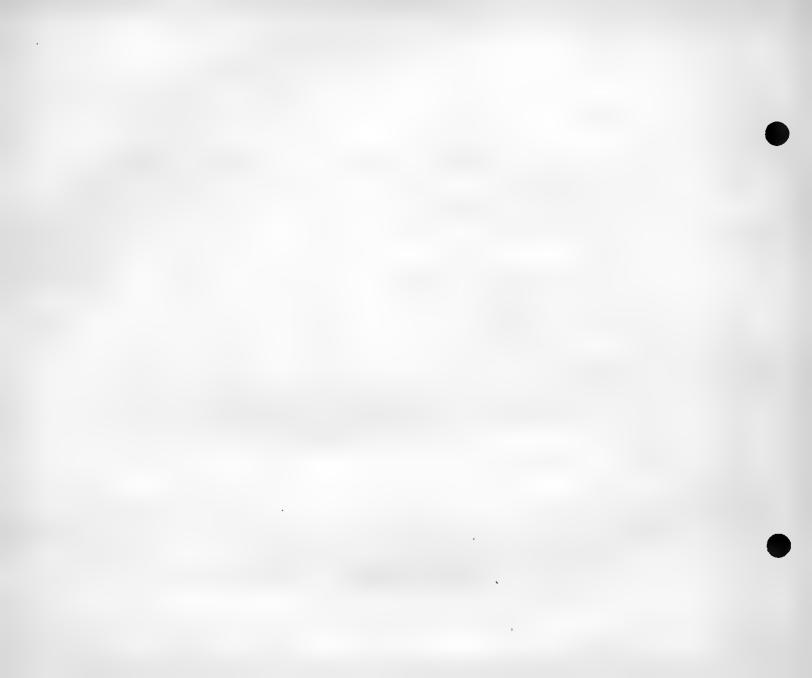
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after deats PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY p. STATE b. COUNTY Montgomery Maryland MARYLAND b CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) in by Baltimore Gaithersburg d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e 15 RESIDENCE ON A FARM? filled Asbury Methodist Home for the Aged. Inc. 4500 Hampnett Avenue NO T YES NAME OF 4. DATE Month remove corbon Dov Year ond completely DECEASED 19 67. Blanche Simonds (Type or print) Henry July DEATH IF UNDER 24 HRS 6. COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARRIED lost birthdoy) Months DIVORCED TO WIDOWED June 30, 1885 ond in ony 19 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) attending physician operation of the please INDUSTRY Baltimore, Md. housewife 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, Curtis Bennett Simonds Katherine Ohlgart 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor of dates of service) 215-54-8925 Asbury Methodist Home, Gaithersburg, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (i)), (b), ond/(c).
PART 1 DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. **DUF TO** Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse this certificate has been 19. WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO 20o. ACCIDENT WAS UNDERLYING ... 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) at work 21. I certify that (1) (this baspital) attended the deceased from 5/28/63, 19 ta. 7./19 6 7, 19 that (1) (we) last and that death occurred at 5300 M, from causes and on the date stated above DIRECTOR: saw the deceased alive an 220 SIGNATURE 22b DATE-SIGNED DIRECTOR director, poge should be filed 22d ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type) Henry C. Scruggs, M. D. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23d LOCATION (City or Town) ((County) (Stote) Cremation 7/20/67. Greenmount Crematory Baltimore, Md. 0 24 FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto, Md. 21214 25b REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Williams Judas



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09786 09761 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY o STATE b. COUNTY MARYLAND nan papers. Pages 1/ Mathin 72 hours after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR NSTITUT ON (If not in hospital, give street address e IS RESIDENCE ON A FARM? Filled NO V NAME OF Middle carban DATE Year DECEASED (Type or print) DEATH SEX IF UNDER SE UNDER 24 HRS ATE OF BIRTH 9. AGE (In years **NEVER MARRIED** lost birthdoy) Months Days Hours WIDOWED OLVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT and in post of working life, even if retired) COUNTRY? attending physician permit. Then please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown), (If yes give wor or dotes of service) 3077 crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) ACUTE CONGESTIVE 6 1412 signed burial burial, Conditions, if any, which gave " 16 4RJ rise to immediate couse (a), **DUE TO** stating the underlying couse as the priar to l PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS PERFORMED? Health NO certificate 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) detached for the Dept. of I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJRY Month, Doy, Year (City or town) (County) (Stote) Hour om. Not While factory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased from 1965, 10 JULY 19 CZ, that (I) (we) los JUNG be retained 62 and that death occurred at 950 M, fram causes and on the date stated above saw the deceased alive on\_ O FUNERAL DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS MED. DIRECTOR M.0 PHYS 22d\_ADDRESS 22c. PHYSICIAN'S NAME (Type) WISCOWSIN AND BETHENNA director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b DATE THEREOF (Stote) REMOVAL (Specify) July 8,1967 Mount Olivet Cemetery Frederick, Maryland 2So. REC'O BY REGISTRAR 2Sb REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 M. R. Etchison & Son, Frederick, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09762 29757 CERTIFICATE OF DEATH requires that the dooth certificate be executed within 24 hours oftom death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY COUNTY within 72 hours after MARYLAND Montgomery b CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURA, and give negrest town akoma d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? papers YES NO D NAME OF Year **DECEASED** (Type or print) orothea DEATH 1967 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. remove lost birthday) White WIDOWED DIVORCED Jan. 2. 1885 100 USEAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Norway 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal. Edward 15 WAS DECEASED EVER IN L. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) WSH 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) ) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p burial, cremati ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions if only, which gove ) rise to immediate couse (a), DUE TO tor use as the l Health prior to b stating the underlying couse (() PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? NO TO FUNERAL DIRECTOR: After this certificate 20b. ACCIDENT WAS JNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF FITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, (C ty or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour 'o.m. foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased from Day 196/ to Tul be retained director, page 3 should should by tiled with the 19.67, and that death occurred at 4:25 PM, from causes and an the date stated above. saw the deceased alive an 72(4 22o. SIGNATURE 22b DATE SIGNED M.D. DIRECTOR 22c. PHYSICIAN S 22d ADDRESS NAME (Type) 23 BUR AD CREMAT ON, NAME OF CEMETERY OR CREMATOR **EOCATION (Citypor Town** (Stote) REMOVAL (Specify) 2Sb REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09768 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) filled in by the funeral papers. Pages 1 ord P COUNTY OU F COME IA . COUNTY montgenery MARYLAND b. CITY OR TOWN (If autside caredrate limits. CLENGTH OF STAY IN 1h c. CITY OR TOWN (If gutside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) 72 hours Rockville d. STREET ADDRESS e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Argyle Street 19 Argvle Street within YES NO THE NAME OF Middle 4 DATE Last Month Year physician and completely DECEASED July 27. 19 67 HIGGINS KATE HYATT event (Type or print) DEATH pleose remove car S SEX DATE OF BIRTH 9 AGE (in years IF JNDER I YEAR | IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED birthday) Months Doys Hours Sept. 21, 1894 White Female and in any WIDOWED 10o USUA, OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working tife, even if retired) COUNTRY? INDUSTRY N. Carolina TISA 14. MOTHER 5 MAIDEN NAME 13 FATHER S NAME cremotion, or removal, signed by the attending phy burial-transit permit. Then Mar aret Griffith James L. Hvatt IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO Address (Yes, na, ar unknown) (If yes give war or dates of service Clara Lee Hvatt-Item # 2 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c) PART 1. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physicion. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO burial, Conditions, if any, which gave rise ta immediate cause (a). DHE TO stating the underlying cause os the prior to last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use State Dept. of Health NO YES [ 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING . OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg., etc.) Not While at wark at work should be . 1960, ta July 27, 1967, that (1) (see) last 21. I certify that (1) (this-haspital) attended the deceased from 27 1967, and that death accurred at 1:30 PM, from causes and an the date stated above saw the deceased alive on xul r, poge 3 shou be filed with 1 22a, SIGNATURE 22b. DATE SIGNED ATTENDING MED DIRECTOR 7/27/67 erine. M.D. ADDRESS 22c PHYSICIAN'S Washington St., Rockville, Md. NAME (Type) Corinne Cooper director, should be 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)
Bur-Transit Gaston Memorial 2Sa, REC'D BY REGISTRAN Funeral Home-1331 Rockville Pik VR A15 (4) 20 M 1/66 Rockville Maryland



	1 01	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	8	CERTIFICATE OF DEATH
ath.	ath.	1. PLACE OF DEATH    2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
after death	気がある	a, COUNTY b COUNTY
ıfteı	都都	Montgomery  MARYLAND  b. CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
2	2 Page	T. welte. Rural_and_give nearest town)
24 hours	d in the Pour	"ashington, D. C. 4,
	y filled papers thin 72 h	Kensington Gardens Nursing Home 4321 Argyle Terrace N.W. YES NO
擅	completely by carbon p	3. NAME DF First Middle Last 4. DATE Month Day Year DECEASED Vision Annual Table 2. The DF
% •	扩展营	(Type or print) Virginia Ann Hildebrand Death July 30, 1967 19
executed within	See A	5. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  19. AGE (In years) IFUNDER 1YEAR IFUNDER 24 HRS last birthday) Months Days Hours Min.
exe	是是	WILLUE   WISHES IX
	sician lease and ir	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or fereign country)  12. CITIZEN OF WHAT COUNTRY?
ite	ple 7	Housewife Virginia U.S.A.  13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ilica i	Then properties of the propert	m. It
Series	iệ la	Thornton F. Berry   Lucy Hicks 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address
45	attending physician rmit. Then please in, or removal, and in	(If yes give war or dates of service)  Julia Mushinsky 5842 Oregon Ave. N. W
dea	he a	dilla manilina yeshington D.C.
requires that the death certificate be	been signed by the atter the burial-transit permit, or to burial, cremation, or	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I, DEATH WAS CAUSED BY:  ONSET AND DEATH  ONSET AND DEATH
hat	2 to 20	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AC. MY GOOVED IN TOVE TONE  ONSET AND DEATH  ONSET AND DEATH
law requires that the	E E E	Consistent to any which I do not not not not not not not not not no
pulre o n	5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	gave rise to Immediate
Je Li	has been as the prior to	cause (a), stating the DUE TO At the WOCCES
Jaw Ptte	has as	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
The	for use of the Health p	YES NO X
== 0	of He of the	
PHYSICIAN:	After this certificate has a be detached for use as a State Dept. of Health price.	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHY	offer this of be detache State Dept.	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
	Tage ff	Hour a.m.  While Not While at work at work at work at work
ATTENDING retained by		21. I certify that (I) (this hospital) attended the deceased from 1907 to 1907 to 1967, that (I) free last
TTE	S show with t	saw the deceased alive on July 25 1967, and that death occurred at 630M, from the causes and on the date stated above
OR A	E SE	22a. SIGNATURE 22b. DATE SIGNED
Page 1		ATTENDING MED. STAFF DIRECTOR PHYS.  22c. PHYSICIAN'S  M.D. ATTENDING MED. STAFF DIRECTOR PHYS.
<u> </u>	ERA De	NAME (Type) F. III NIC NIG STORY
D HOSPITAL Page 4 may	of FUNERAL DIRECTOR.  director, page 3 should be filed with the fi	23a. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)
2	5 g & 2	REMOVAL (Specify)
		burial 8/1/67 Rock reek Cemetery Washington D. C. 24. FUNERAL DIRECTOR H. Hines Company 25a. REC'D BY REGISTRAR 25b. REGISTRAR
VR	A15 (4)	2901 lith St. N. W. wash. D.C. DATE AUG 1 1957 yourses yuse
	A 1/65	LANA AMUNI TO NO. WO. W.



7 1	Items 18&21 Film 390 7-1 <b>MARYLAND</b> STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
EOD STATE	39765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	09770
FOR STATE		
. 5 8 4 IXI	a COUNTY  MARYLAND  b CITY OR TOWN At autside corporate Arts,  while RURAL and g we nearest rown)  c CITY OR TOWN At autside corporate I m ts white RURAL and g we rearest rown)	Peorgé
form PA	d. NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street address)  1 Jakoma Park  d. STREET ADDRESS  1 Jakoma Park  2 Jakoma Park  1 Jakoma Park  1 Jakoma Park  2 Jakoma Park  3 Jakoma Park  4 Jakoma Park  1 Jakoma Park  2 Jakoma Park  3 Jakoma Park  4 Jakoma Park	e IS RESIDENCE ON A FARM? YES NO
og winning of the Sto	3 NAME OF PIEST Middle Lost 4 DATE Month OF OF DEATH  5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years IF-UNDER	Day Year 4 19 6 7 1 YEAR   IF NOER 24 HRS
Tours ofter 18. Grant 18. Grant 19.	Female Negro WIDOWED D D VORCED D VORCED D Lost birthday) Manths  Oo US AL OCCUPATION (Give kind of wark done libb K ND OF BUSINESS OR II. BIRTHPLACE (State or fareign cauntry)  NOTIFY OF THE PLACE (State or fareign cauntry)	Days Hacrs Min  IZEN OF WHAT  UNTRY?
d within 24 Tours o in pencil in Item 18. Examiner's Office al File pages 1 and 2 wi	13. FATHER'S NAME	
id b∎ exec∎ted within 24 ∏ours of pending" in pencil in Item 18 Chief Medicol Examiner's Office of tronsit perm‡ File poges Jond2 weent within 72 hours after deoth	15 WAS DECEASED EVER IN S ARMED FORCES?  (Yes, no or unknown) (fyes give war or dates of service)  218-56-3402 Hattle Thus Ton-813 Colby	AUE.
MINER: This certificate should be executed within 24 Bours off the certificate, writing the word "pending" in pencil in Item 18. G should be farworded to the Chief Medicol Examiner's Office alour files.  I files.  Should be used as a buriol-transit perm? File pages land 2 with notion, or removal, and in any event within 72 hours after death.	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)  PART I DEATH WAS CAUSED BY  IMMEDIATE CAUSE (a) Phillip/ Malnutrition  1422/ DUE TO	INTERVAL BETWEEN ONSET AND DEATH Weeks
MINER: This cert ficate should the certificate, writing the ward 4 shauld be farworded to the Christines. In files.  e 3 should be used as a buriol-transton, or removal, and in any evention, or removal.	(conditions, if only which gave inse to immediate cause (a), stating the underlying couse (b)  (c) Generalized arterio Sclerosis	Years Years
this cert fur ote, writing the farword be used to emovol, a	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS A TOPSY PERFORMED? YES NO
EXAMINER: This cert sute the certificate, writing 4 shauld be farwo your files. Page 3 should be used cremotion, or removol,	200 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item IB.)  PRIMARY II or CONTRIBUTING II CAUSE OF DEATH.  20x TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Hame farm, 20f (City or town) (Contribution)	unty) (State)
L EXAMINER: ecute the certi Page 4 shauld for your files. R:Page 3 shou II, cremotion, o	Hour a.m. p.m.  19 While at work at work factory street, affice bidg etc.)  21. I certify that I took charge of the remains described above, held an Autopsy , aspection , Inquiry ,	
MEDICAL EXA pleose execute d'rector Page retained for you DIRECTOR: Poge in to buriol, cren	deoth resulted from: Notural couses XJ, Accident , Suicide , Homicide , Undetermined monner CHIEF MEDICAL EXAMINER	
O DEPUTY MEUCIAL EXAM necessory, please execute the funeral director Page 4 5 may be refained for your D FUNERAL DIRECTOR: Page Health prior to buriol, cremo	SIGNATURE  SIGNATURE  M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	22. DATE SIGNED
To Di	230 BURIAL (REMATON, REMOVAL (Specify)  230 DATE THEREOF  PEMOVAL (Specify)  7-8-67  230 DATE THEREOF  PROMOVAL (Specify)  7-8-67  230 NAME OF CEMETERY OR CREMATORY  Harmony Memorial Park  230 DATE THEREOF  Prince Georges, Part of Company  230 LOCATION (City or Town)  Prince Georges, Part of Company  24 FUNERAL DIRECTOR John T. Rhines CO  ADDRESS 3015  250 REGISTRARS S	
VR A15ME (5)		By Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09771 20288 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest/town) b. CITY OR TOWN (If outside corporate limits. write RURAL and give nearest town n any event, within 72 haurs OCKUILL d NAME OF HOSP TALLOR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENCE ON A FARM? YES 3. NAME OF Middle DATE Doy Year remave carban Max DECEASED (Type or print) OF DEATH 19 6 IF UNDER 1 YEAR SE JNDER 24 HRS 9. AGE (In years S. SEX 6 COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH ast birthdoy) DIVORCED WIDOWED 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Store, or foreign country) CQUNTRY? during most of working life even if retired) INDUSTRY Pman4 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Anna (Unknown) Unknown burial, crematian, or remak IS. WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. **INFORMANT** Address (Yes, no, or unknown) (If yes give wor or dates of service) NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for to) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) the haspital ar attending physician. DUE TO Conditions, if only, which gove nse to immediate cause (a), DUE TO stating the underlying cause far use as the Health prior ta th s certificate has been 19 WAS AUTOPSY PERFORMED? PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 1B.) 20a ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or fown) (Stote) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, (County) 20c. TIME OF INJURY Month, Doy, Year Hour om factory, street, affice bldg , etc.) Not While at work of work 21. I certify that (1) (this hospital) attended the deceased from Movember, 1964, to 1967, and that death accurred at 1217AM, drop causes and an the date stated obove O FUNERAL DIRECTOR: saw the deceased alive on. 226 DATE SIGNED 22o. SIGNATURE M.D Viers Mill 22d ADDRESS 809 NAME (Type) Robert Macon Rockville, Maryland director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23b DATE THEREOF (County) 230 BURIAL, CREMATION, Buryal Specty) Rockville, Maryland 7-11-67 Parklawn Cemetery 25b REG STRAR'S SIGNATURE 250 REC'D BY REGISTRAR 24 FUNERAL DIRECTOR PUMPHREY, Bethesda, Maryland VR A15 (4) 25M 1/67



STATE DEPARTMENT OF HEALTH RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) COUNTY b. COUNTY MARYLAND MONTGOMERY JERSON NEW b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside apparate limits, write RURAL and give negrest town) RURAL and give nearest town) SILVER SPRING FORT LEE d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? HoRizan House FLORA YES NO F 710 LANE NAME OF Middle Holm-Anderson 4. DATE Yeor DECEASED (Type or print) THORBJORG MARIA DEATH JULY 19 67 6 COLOR OR RACE 7 MARRIED WEVER MARRIED B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS JUNE 1, 1911 WIDOWED [7] DIVORCED [ 56 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? ICEZ AND U.S. HOUSEWIFE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ODDNY VIGEUS DOTTIR. INGOLFUR GISLASON, 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT FLORA LANE MRG. THORS AGUSTA ILVER SPRING, MD 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY HEXET 5 MINUTET ACUTE FAILURE IMMEDIATE CAUSE (6) **DUE TO** SEVEKA CHRONIC MYOCARDIAL DIFAE AND FAILURE Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO I 20g. ACCIDENT WAS UNDERLYING A
OR CONTRIBUTING ACCUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, farm. | 20f (City or lown) Doy, Year 20d, INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. While Not while of work of work p. m. 21 I certify that (1) (this haspital) attended the deceased from 6/19 4 2 19 67, and that death occurred at 13 PM, from the causes and on the date stated above. saw the deceased alive an TUC 22o S GNATURE M.D. PHYS DIRECTOR [ 22c PHYS CLAN'S NAME (Type) 22d, ADDRESS GEO. AVE, SILVER SPRING MARYLAND ROBERTS 23a BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, fown, or county) REMOVAL (Specify) Rockville Centre. New York 24 FUNERAL ORECTOR ESTE MATURE ELAN MATTE ADDRESS 8434 Ga. AUE. 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE Pumphrey, Inc. Silver Spring, Md. DATE 1SM 9/S9



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 55768 CERTIFICATE OF DEATH andar requires that the death certificate be executed within 24 hours after death. funeral Tang 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) OUNTY MONTGOMERY o. STATE b. COUNTY MARYLAND MARYLAND MONT GOMERY attending physician and completely filled in by the sermit. Then please remave carbon pagets. Pages c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b, CITY OR TOWN (If outside corporate limits r LENGTH OF STAY IN 16 write RURAL and give nearest town) KENSINGTON 11506 Lund Place, Kensington, Md e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Kensington, Md. YES NO NO Place Kensington Md 3 NAME OF Lost 4. DATE Month Year DECEASED MAE HOPKINS July 13 19 67 CLARA (Type or print) DEATH IF UNDER 1 YEAR S SEX 6 COLOR OR RACE 8. DATE OF BIRTH 9 AGE (in years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours white WIDOWED DIVORCED April 21.1936 Female 100 JSUA, OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife COUNTRY? INDUSTRY Missouri 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME remayol. CARL T. CURTIS LOIS WILLE-ATWATER 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT 11506 Lund Place, (Yes, no, or unknown) (If yes give wor or dates of service) No James A. Hopkins Kensington. none 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DIJE TO Conditions, if only, which gove Zealiro by rise to immediate couse (a). DIJE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been the the 2121611 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS PERFORMED? 629 NO ī 206 ACCIDENT WAS UNDERLYING [ 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg , etc.) ot work of work 21. I certify that (1) (this-hospital) attended the deceased fram 7 4 , 1964, to 13 fram, 19-7, that (1) (we) last saw the deceased alive an 3 19 6 2, and that death accurred at 1/2 PM, fram causes and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. PHYS. director, page Should be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL Dimitroff 11300 Woodson Ave. Kensington. Md. NAME (Type) M.D. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION (County) (Stote) REMOVAL (Specify)
Burial Minden City Cem. Minden. Nebraska 250 REC'D BY REGISTRAR 19 1967 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 BETHESDA, MARYLAND ROBERT A.

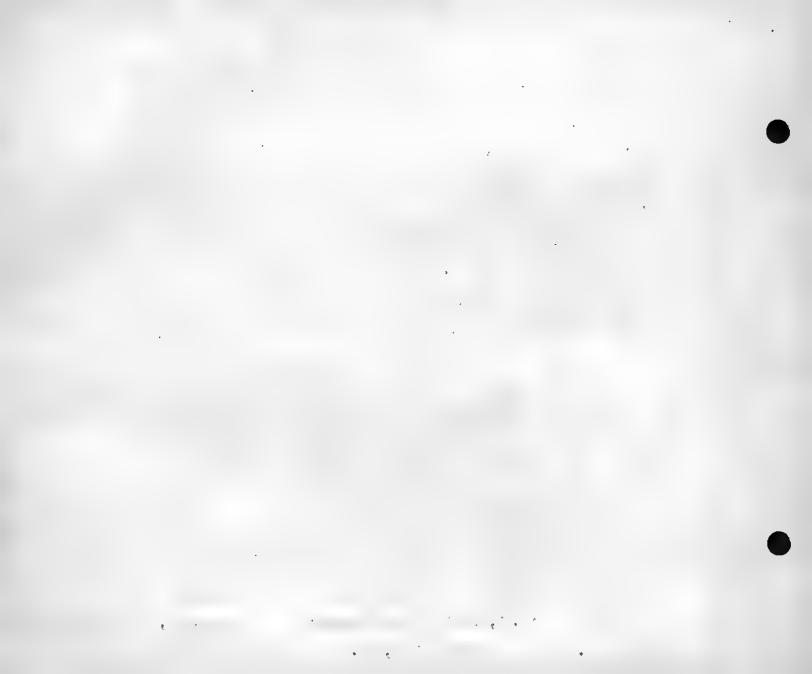


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09769 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after death funeral i 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission STATE a. COUNTY ¢оныту (ITY OR JOWN (If autside producte limits, write BORAL and give nearest tawn) MARYLAND Day c. LENGTH OF STAY IN 16 OWN (If outside carparate limits, write RURAL and give nearest tawn) hes da A NAME OF HOSPITAL OR INSTITUTION (If/not in haspital, give street address) d. STREET ADDRESSe IS RES DENICE ON A FARM? YES NO IL NAME OF Middle DATE Year DECEASED (Type or pont) DEATH comple 9 event 9 AGE (Inchars glast birthday) SEX FF UNDER 24 HRS 6 COLOR OR 7 MARRIED **NEVER MARRIED** DATE OF BIRTH гетоме Months Days Haurs and in any mali WIDOWED DIVORCED 1Da USUAL OCCUPATION (Give kind of work done KIND OF BUSSNESS OF ! BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician ( COUNTRY iring most af working lif 13 FATHER S NAM. 14. MOTHER'S MAIDEN NAME remova WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, np. or unknown) (If yes give wor or dates of service) 5 cremotian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART | DEATH WAS CAUSED BY buriol-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by by the hospital or attending physician. DUE TO burnol, Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause prior to l frote has been as the 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dept. of Health NO A YES df. 20g ACCIDENT WAS UNDERLYING [ 20b DESCRUBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B) OR CONTRIBUTING I CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER' 20e. PLACE OF INJURY (Hame, form (City or tawn) (State) 2Dc. TIME OF .NJURY Manth, Day, Year 2Dd INJURY OCCURRED (Caunty) Hour a.m. factory, street, affice blda., etc.) Not While at work O FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 1967, that (1) (we) los 19 67. to O HOSPITAL OR ATTEND Poge 4 may be retained 3 1967, and that death occurred at 2:074 Moram causes and an the date stated above saw the deceased alive an 220 SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR director, page 3 should be filed a M.D. PHYS 22d. ADDRESS 22c, PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Jown) 23g. BURIAL XREMATION DATE THEREOF (County) (Store) B BY REGISTRAR VR A15 (4) 25M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09 7 11, CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE **b.** COUNTY papers. Pages I hin 72 hours after MARYLAND etely filled in by the factors. Pages b CITY OR TOWN (If outside) carparate (mit) write RURAL and give nearest town) E LENGTH OF STAY IN 15 c CITY OR TOWN (If autitide corporate limits, write RURAL and give nearest town). PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft MoS. d STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) YES NO V NAME OF Last DATE Manth Day Year DECEASED OF DEATH 0 La n 19 6 physician and compl S SEX IF UNDER 1 YEAR F UNDER 24 HRS 7 MARRIED **NEVER MARRIED** DATE OF BIRTH (In years last b rthdoy) Months Hours Dovs remoj WIDOWED V DIVORCED 10n HSJAL OCCUPATION (Give kind of work done TOB. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) ENDUSTRY COUNTRY? please .S.A. audour Coun Housewi 0011 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME or removal, E G signed by the attending INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECHIEITY NO (Yes, no, ar unknown) (If yes give war or dates of service crematian, 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse as the 2 this certificate has been last WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART [40] CERTIFICATION Health NO ā 20o. ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH of of detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour o.m. Nat While factory, street, affice bldg., etc.) of wark L ot work O FUNERAL DIRECTOR: After þe 21 I certify that (I) (this haspital) attended the deceased from be retained shauld and that death accurred at 1134 M. from causes and an the date stated above. saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED ATTENDING PHYS M.D. PHYS , page be filed ADDRESS 22c. PHYSICIAN'S Page 4 may NAME (Type) directar, shauld b BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 1.967 Union Cemetery Leesburg Loudoun Aug. 24 FUNERAL DIRECTOR 250. RECT BY REGISTRAR 198725b. VR A15 (4) 20 M 1/66 DATE A Francis H. Barber Laytonsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

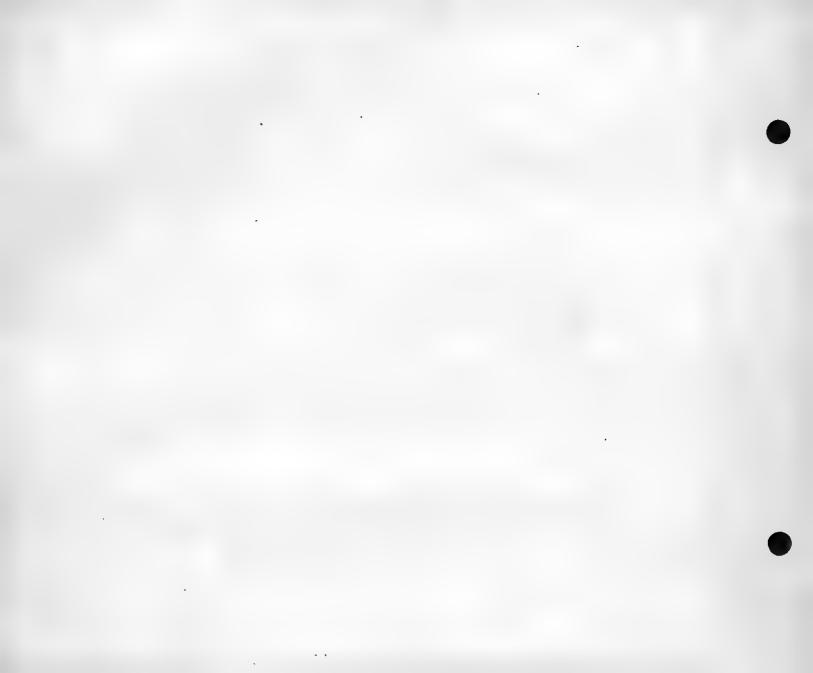


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. COUNTY Montgomery Montg. a. STATE Maryland **b.** COUNTY MARYLAND b. CITY OR TOWN (if oulside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give genrast lown Rura Germantown. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Rural, Rt YES 📉 NO 7 3. NAME OF Middla DATE Month DECEASED Joseph (Type or print) Howes Green DEATH July 196 carbon 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS pue 7. MARRIED TI NEVER MARRIED death certificate be last birthday) Male Whi te Nov 15th 1880 WIDOWED 10a, USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 112. CITIZEN OF WHAT COUNTRY? Ret—Farmer Pelli Farming Montg. Co. S 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ā James  $\mathbb{R}$  . Howes Eliza Green 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyasgivawarordatasofsarvica J. Dorsey Howes . As No 2-18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY, . IMMEDIATE CAUSE (a) divorscular disease Conditions, if any, which gave rise to immediate causa DUE TO (a), stating the underlying causa last. PART I., OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 206 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCUPRED. (Enter nature of Injury in Part I or Part II of Itam 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) lached ATTENDING 20c TIME OF INJURY 20d. INJURY OCCURRED | Month, Day, Yaar 20s. PLACE OF INJURY (Home, farm, 20f. (City or lown) (Stata) (County) factory, streat, office bldg., atc.) Hour am Whila Not While DIRECTOR at work at work p.m. 21. I certify that (I) (this hospital) attended the deceased from I.Q. should ate saw the deceased alive on DIGNATURE DATE ATTENDING MED. STAFF HOSPITAL FUNERAL DIRECTOR PHYS. PHYS. M.D PHYSICIAN'S 22d\_ADDRESS TO FUNE director, I NAME (Type) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) {Stala REMOYAL (Specify) Neelsville Presbyterian Burial Germant.own 256 PEGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURES ADDRESS 25s. REC'DIRY REGISTRAR VR A1S (4) DATE Gai thershurg 20M 5-63



	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND	21201
. 8	09772 CERTIFICATE OF DEATH	Calledia
24 haurs after death ed in by the funeral spers. Pages 1 and 2 Agents.	1. PLACE OF DEATH a. COUNTY  DOWN (If outside corporate limits, write RURAL and give negress town)  DOWN (If outside corporate limits, write RURAL and give negress town)  STATE  C. CITY OR TOWN (If outside corporate limits, write RURAL and give negress town)  TORYS  WAS No. TORYS  WAS No.	
completely filled in base completely filled in base confermed pers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress)  A. RIAND NURSING HOME  3. NAME OF First Middle Lost 4. DATE Month  DECEASED  DECEASED	e IS RESIDENCE ON A FARM? YES NO P
e executed wand complete	CType or print)   CTYPE or p	ths Doys Hours Min 2 CIT ZEN OF WHAT
n certificate be ing physician o Then please emoval, and ir	duting most of working life, even if retired) — INDUSTRY  13 FATHER S NAME  LEWIS BORK WALTER  14 MOTHER'S MALDEN NAME  ANN A SUITNER  15 WAS DECEASED EVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY NO. 17 INFORMANT  Address	COUNTRY? U.S.
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death be retained by the haspital ar attending physician.  SIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral is 3 should be detached for use as the burial-transit permit. Then please remove copean appears. Pages I and it is 3 should be detached for use as the burial, cremation, or removal, and in any event, within 2 hours after death ed with the State Dept. af Health priar to burial, cremation, or removal, and in any event, within 32 hours after death	(Yes, no, or unknown) ((If yes give wor or dotes of service) 2/8-34-7/34B,  18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE (AUSE (a)  OUE TO  Conditions, if any, which gave rise to immediate cause (a), DUE TO  DUE TO  DUE TO	INTERVAL BETWEEN ONSET AND DEATH
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached for use as the burial-transhauld be filed with the State Dept. af Health priar to burial, cre	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)  THE VIOLENT AS UNDERLYING OF CONTRIBUTING OF	PERFORMED?  YES NO E
TENDING PHYS ined by the has RR. Affer this ce build be defache the State Dept.	20c. TIME OF INJURY Month, Day, Yeor While of work of work of work of work of work 19 Otherset of work 19	(County) (Stote)  1927, that (I) (we) lose the date stated above
TO HOSPITAL OR ATTEND Page 4 may be retained TO FUNERAL DIRECTOR: A director, page 3 shauld shauld be filed with the	220 SIGNATURE  WELL-VE_MD. ATTENDING MED. STAFF 22  22c. PHYSICIAN'S NAME (Type)  22d. ADDRESS NAME (Type)  2121 Penn Dire NU	July 67 Wash De
TO HO: Page TO FUN direct shaul	230. BURIAL, CREMATION, BEMOVAL (Specify) 7-20-67 Cedar Hill Cemetery Suitland. Machine of Cemeters of Cemet	(County) (Stote) arvland R'S SIGNATURE
VR A15 (4) (1)	Lee Funeral Home 300 4th St.NE Wash., D. Obne. 20 1967 Clark	es Juage

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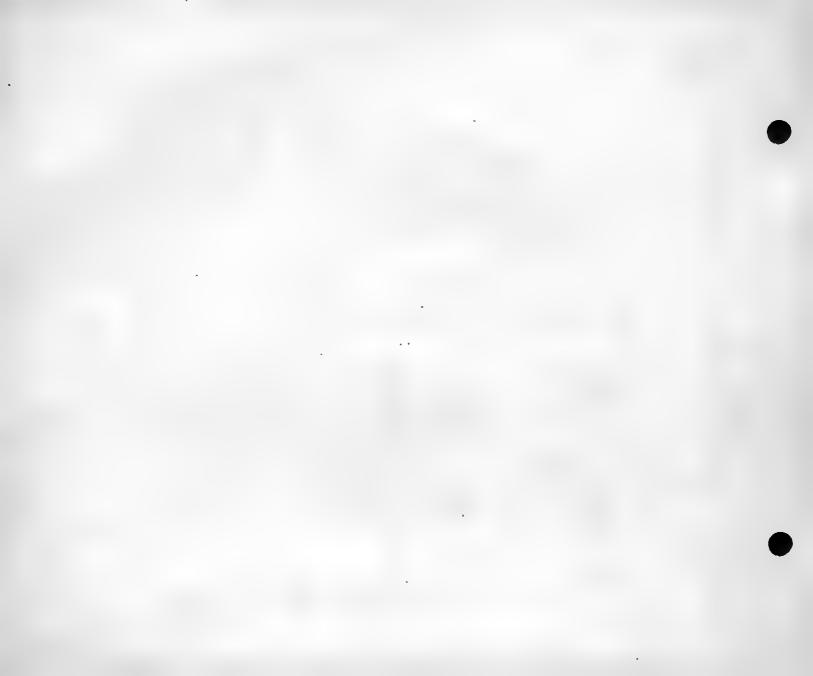
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09773 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o STATE o. COUNTY **b** COUNTY Montgomery Marvland MARYJAND Montgomery b CITY OR TOWN (If outside corporate I mits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) requires that the death certificate be executed within 24 haurs aft write RURAL and give nearest town Silver Soring papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? and campletely fitter in 1220 Blair Mill Road 1220 Blair Mill Road YES NO TO 3 NAME OF Middle 4 DATE First Last Month Day Year DECEASED ALBERT HYATT carb 1967 July (Type or print) DEATH IF UNDER 1 YEAR 1F UNDER 24 HRS. 5 SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthday) Months Days Hours White Male 23/14 WIDOWED DIVORCED 12 CITIZEN OF WHAT 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY USA Manufacture Rep Russia 13. FATHER'S NAME 14 MOTHER S MAIDEN NAME Norman Hyatt Rose Krasner 17 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, na or unknown) (If yes give war or dotes af service) Ronald Hyatt, Son, (See 2 above) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN signed by the burial-transit p ONSEL AND DEAT PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave nse to immediate cause (a). DUE TO as the prior tal stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPS' PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) YES 🗀 NO 205. DESCRIBE HOW INJURY OCCURRED (Enter Nature of injury in Port I or Port II of item 18. 200 APC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Not While 21. 1 certify that (1) (this haspital) attended the deceased fram, 19 67, and that deoth occurred at 10 M, fram causes and on the date stoted above. saw the deceased alive on. DATESIG 22n SIGNATURE **ATTENDING** STAFF PHYS. DIRECTOR director, page 3 shauld be filmd v 22c. PHYSICIAN 22d. ADDRESS POC NAME (Type) 230 LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION (County) (Stote) REMOVAL (Specify) 8/2/67 Beth Israel Cem. Washington, Pa. 256 REGISTRAR'S SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Trapley VR A15 (4) 20 M 1/66 Goldberg Funeral Home - 4217 9th Street N.W. DATE



4	- 1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	e ret		CERTIFICATE OF DEATH
	after death. the-funeral	1.	- ACHIETY
	ate the state of t		Manyland Maryland Manyland
			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest fown)
	3 E 0	-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
	n 24 ho Filled i papers. hij 72 h		2112 Dexta Coul 2112 Dextar Coul YES NO
	executed within and completely femove carbon in any event, within	3.	NAME DF First Middle Last 4. DATE Month Day Year TOPPORT (Type or print) FLORENCE EMILY INSCEE DEATH Suly 15 19 67
	e é co	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE UN years If UNDER 1 YEAR IF UNDER 24 HRS.
	execute and co remove	10	Deman Wylle Widowed Divorced July 13, 1903 64 yrs.
		đũ	a. USUAL DCCUPATION (Give kind of work done industry) 12. CITIZEN OF WHAT (COUNTRY) 12. CITIZEN
	icate phys n plo val, a	13	FATHER'S NAME
	ding ding remo		Harry Mus annie & Danford
	requires that the death certificate be exection physician. been signed by the attending physician and the burial-transit permit. Then please remont to burlal, cremation, or removal, and in any	Įά	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  MS, NO. or Amkown) (If yer Give year or dates of service)  Address
	the de nation		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I DEATH WAS CAUSED BY.  ONSET AND DEATH
	at the silan. It of by trans crem		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARLINGTON Charles 12-15 mm
	hysic hysic signe rrial- rrial-		Conditions, If any, which
	and plants of the plants of th		gave rise to immediate (b) cause (a), stating the DUE TD
	rendi as b as th	Z	underlying cause last. (c)
	ENDING PHYSICIAM: The law requires that the sined by the hospital or attending physician. DR: After this certificate has been signed by thould be detached for use as the burial-transit the State Dept. of Health prior to burial, cremains the State Dept.	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES 1 NO 1
	AN: pital rtific of Ho	RTIFI	2Da. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)  DR CONTRIBUTING   CAUSE OF DEATH
	hos hos is ce ache ept.		(IF EITHER, NOTIFY MEDICAL EXAMINER)
	oy the ser the det	MEDICAL	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (County) (State)  Hour a.m.   While   Not While   factory, street, office bldg., etc.)    p.m. 19   at work   at work
	NDIN ned to lid b	*	21. I certify that (1) (this hospital) attended the deceased from 1944 to 15 July 1947, that (1) (we) last
	ATTE retain CTOR shor		saw the deceased alive on 13 19 and that death occurred at 19 M, from the dayses and on the date stated above.
	DIRE DIRE Jed w		William Stand M.D. ATTENDING DIRECTOR   STAFF   7/1)7/7
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cre		220. PHYSICIAN'S NAME (Type) WILLIAM D AUD 9006 Columbia Rd. July Sp. Md
	Page Page Frun direct	23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
		2	BUNEAU JULY 18 1967 FOUR KIN COLD CUMULUS COLOMA MANOR 19 REGISTRAR'S SIGNATURE
	VR AI5 (4)		arthur Walters 254 Corrol SINIU Walfill C JH 19 1967 geliarles Judge
	2DM 1/65	15	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 99775 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY N COUNTY ONTGOMER MARYLAND vån papers. Pages 1 within 72 hours after C JENGTH OF STAY IN 16 CITY OR TOWN (If autside corparate inmits, write RURAL and give nearest lawn) write RURAL and give nearest tawn 670 SILVER filled in I d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS S RESIDENCE 3. NAME OF Middle DATE Manth Year DECEASED DSE AKOFF OF 1967 (Type or print) DEATH S. SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Manths Days Haurs WIDOWED DIVORCED lease rem and in an 10b KIND OF BUSINESS OR 10a USUAL OCCUPATION (Give kind of work done 12 CT ZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) INDUSTRY COUNTRY ? US51A 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. 16. SOCIAL SECURITY NO 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address (Yes, na\_ar unknown) (If yes give war ar dates of service) burial, crematian, signed by the c burial-transit p CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO tar use as the l Health priar ta b stating the underlying cause has been last. WAS AUTOPS PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? certificate f NO X 20a ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Nat While at wark O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from , 1962, that (I) (we) las 7 and that death accurred of 40 mm, from couses and on the date stated obove sow the deceased alive on 22a, SIGNATURE 22b DATE SIGNED ATTENDING STAFF M.D. DIRECTOR PHYS. 22d ADDRESS 22c PHYSiCIAN'S NAME (Type) Z director, shauld 23a-BURIAL, CREMATION 236. DATE THEREOF NAME OF CEMETERY OR CREMATOR LOCATION (City or Town) (County) (State) FUNERAL DIRECTOR



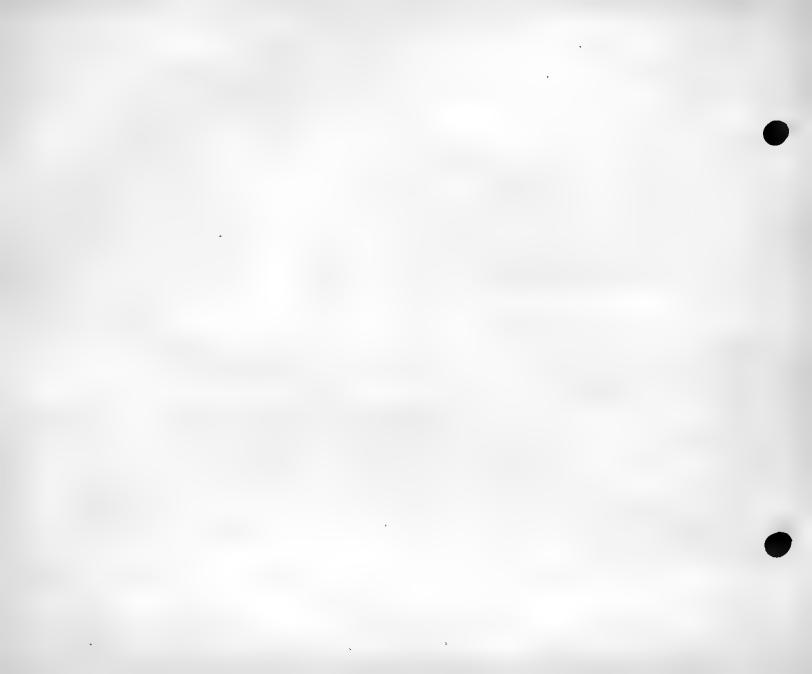
1	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	09776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1 PLACE OF DEATH Q COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Q STATE B COUNTY
delgy j and 3 t	OTTY OR TOWN (II auts de carparote limits, write RURAL and give nearest town)  OTTY OR TOWN (II auts de carparote limits, write RURAL and give nearest town)
If any of I, 2, at PM	Dethileda It days Dincircle
to to	Delected Logital Respectation (If not a hospital, give street address)  a STREET ADDRESS  A STREET ADDRESS  A STREET ADDRESS  WHO I SHOW IN FARM?  YES NO [
fter death Give Pag ong with Ith the Sta	3 NAME OF DECEASED Frs1 Middle Lost 4 DATE Month Day Year OF (Type or print) Chand DEATH Quely 3 1967
hours after death Item 18 Give Pag Office along with I and Ewith the Sto	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARR ED 8 DATE OF B RTH 9 AGE (1) Years 1 FUNDER 1 YEAR 1F NOER 24 HRS
ffice I	100 USUAL OCCUPATION (Give keet of work dane 10b K ND OF BUSINESS OR 11 B RTHPLACE (State or foreign country) 12 CITIZEN OF WHAT
thin 24 thin in It niner's Capages 14 pages 14 ours after	during most of working the, even if returned).  MOUSTRY  MOUSTRY  MOTHER'S MAIDEN, NAME  14 MOTHER'S MAIDEN, NAME  OUNTRY? 45. A
with n penal kamine ile paga	Gergamin Jackson Class Brooks
ld be executed with n 24 r rd "pending" in pencil in It Chief Medical Examiner's O fransit permit. File pages 14 event within 72 haurs after	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ng, or unknown) (If yes give, wor or dates of service)  16. SOCIAL SECURITY NO.  17 INFORMANT  Wife Transces Orders Same as above
e executi pending" ef Medico isit permi	CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY  MARDIATE CAUSE (a)  BRAIN  A 135CE 55  INTERVAL BETWEEN  ONSEI AND DEATH  ONSEI AND DEATH
shauld be e ne ward "per a the Chief I burial-transit	110'5 DIE TO
s certificate shauld e, writing the ward farwarded to the Ch used as a burial-tro laval, and in any ev	(anditions, if any, which gave is to immediate course (a), DUE TO  (b) Frect. SKULL - Comminuted of Compound OK DAYS
writhcote si writing the rwarded ta sed as a bu //al, and in c	stating the underlying cause (c) Tanona -
his certiliate, writh the farwar be used emayal,	PART 1 OTHER SIGN F CANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1(a)  19 WAS AUTOPSY PERFORMED? YES NO
	200 EXTERNAL CAUSE WAS PRIMARY FLOr CONTRIBUTING CAUSE OF DEATH  200 DESCR BE HOW MURY OCCURRED (Enter nature of injury in Part or Port I at term 18) CAUSE OF DEATH  Changem Touck Toice Blow up - nim skyllening had
EXAMINER: ute the cert age 4 shault yaur files. Page 3 shau crematian, a	20c TIME OF IN. RY Month Day Year 20d NJURY OVE RRED 20e PLACE OF INJURY (Hame, form, 201 (City or lawn) (County) (State) Hajr, arm While Nat While (grany, street office blag etc., R
L EXAMI cecute th Page 4 for your 98. Page	21 I certify that I took charge of the remains described above, held on Autopsy (2), Inspection (3), Inquiry (3), and n my opinion
<b>4</b> ∆ _ <sup>−</sup> D .2	death resulted from Noturo couses 🔲 , Accident 🔀 , Suicide 🔲 , Homicide 🔲 , Undetermined monner 🗌
	ACTUAL SIGNATURE Of B. B. C. M.D. ASSISTANT MEDICAL EXAMINER ( 22 DATE SIGNED
o DEPUTY necessary, property of may be in the funeral of Funeral Health priority.	EXAMINER'S NAME (Type)  DEPUTY MEDICAL EXAMINER   7/3/67  Address (Street, city, town, or county)
o DE The f	23a BURIA. (REMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Caunty) (State)
VR A15ME (5)	REMOVA (Specily) BURIAL 7/7/67 ROUND OAK CEMETERY SPENCERVILLE MONTG MD ADDRESS 250 RELIEV V RESISTRAR 1967-50 RELIEV V RELIEV V RELIEV V RESISTRAR 1967-50 RELIEV V
6M 1/67	Kalert L. Suawden ROCKVILLE, MARYLAND DATE



MARYLAND STATE DEPARTMENT OF HEALTH



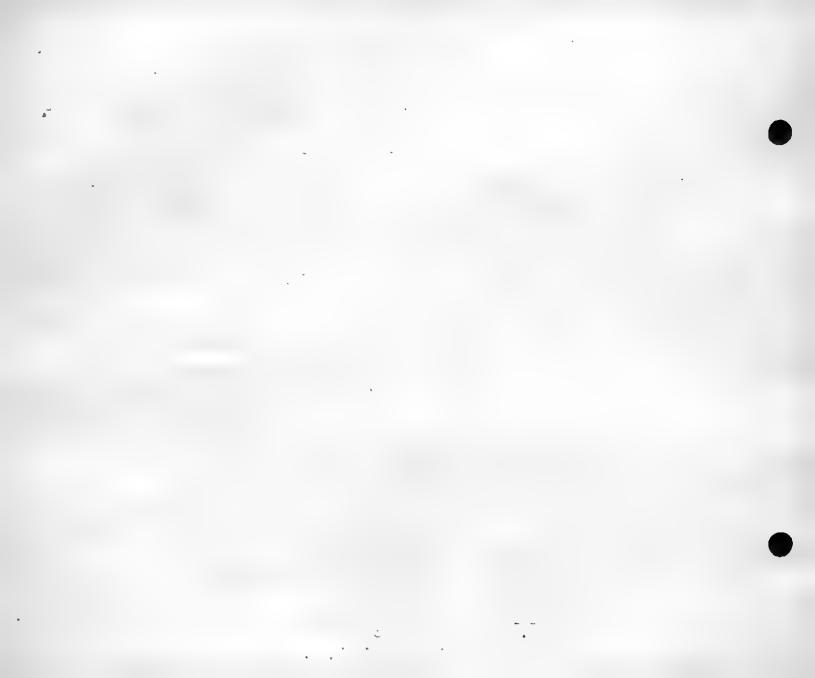
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09778 CERTIFICATE 09783 OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY GomeRU MARYLAND hours after C LENGTH OF STAY IN 16 d NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS NO D PHYSICIAN: The low requires that the deoth certificate be executed within NAME OF Day Year DECEASED OF DEATH (Type or print) 196 7 MARRIED DATE OF BIRTH 9. AGE (In year: IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthday) Manths Hours WIDOWED and in ony DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working ite, even if retired) INDUSTRY COUNTRY? 13. FATHER S. NAME 14 MOTHER'S MAIDEN NA removoľ, 15 WAS DECEASED EVER IN 0.5 ARMED FORCES?
(Yes, no, or unknown) ((If yes give wor or dates of service)) 16 SOCIAL SECURITY NO cremation, IB CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) buriol-tronsit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physicion. Conditions of any, which gove nse ta immediate cause (a), DUE TO stating the underlying cause as the prior to 19 WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) State Dept of Health NO 🗔 YES 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of moury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (Caunty) (State) Hour a.m. factory, street, office bldg., etc.) Nat While of wark at work 21. 1 certify that (1) (this hospital) attended the deceased fram 3-6 , 1967 to 7 - 2 1967, that (1) (\*\*\*) last saw the deceased alive an 6 - 30 1967, and that death accurred at 31502M, from causes and an the date stated above. FUNERAL DIRECTOR: 22a SIGNATUR 22b DATE SIGNED DIRECTOR director, page 3 should be filed v M.D. 22c PHYSICIAN S 22d ADDRESS O HOSPITAL NAME (Type) 23a BURIAL CREMATION 23/2 NAME OF CEMETERY OR CREMATORY 256 REGISTRAR'S SIGNATURE 25a REC D BY REGISTRAR VR A15 (4) 25M 1/67



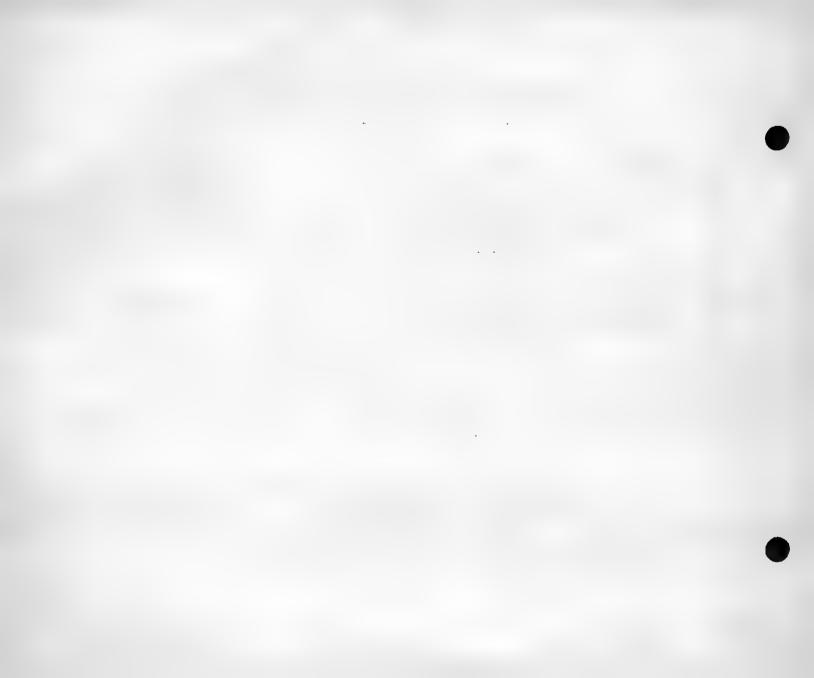
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 69784 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) physician and campletely filled in by the funeral en please remave carbas, papers. Pages 1 and a. COUNTY a. STATE b. COUNTY Virginia MARYLAND Mantagery
b CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Alexandria 3 months Wheaton d NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Ave. 1728 Syron Street ent, within 7 University Nursing Home YES NO X Wheaton. NAME OF 4. DATE First Last Manth Day Year DECEASED OF Jewell 22 William 7 67 Henry 10 (Type or print) DEATH IF UNDER 24 HRS. S SEX AGE (In years IF UNDER 1 YEAR 6 COLOR OR RACE 8 DATE OF RIRTH 7. MARRIED **NEVER MARRIED** birthday) Manths Doys Haurs 7/4/1877 Male Caus. WIDOWED DIVORCED 10a USUAL OCCLPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Leesburg, Virginia USA painter 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME ar removal, signed by the ottending phy Mary Monacker Lewis Jewell 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service 218-24-3740 Annie E. McNeelv Same As # 2 по None INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c),) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse as the O FUNIRAL DIRECTOR: After this certificate has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART !(a) YES [ NO TO HOSPITAL OR ATTENDING PHYSICIAN; I Page 4 may be retained by the haspital ar ţ 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, office bldg., etc.) Nat While at wark at wark 21. I certify that (I) (this haspital) attended the deceased from 19\_\_\_\_ that (I) (we) last 1/ 6 3 1 2 196 7, and that death accurred at the M. fram causes and on the date stated above. saw the deceased alive on. 22o, SIGNATURE 22b. DATE SIGNED ATTENDING STAFF M.D. PHYS DIRECTOR PHYS 22d ADDRESS 6124 Central Ave. Capitol Heights 22c. PHYSICIAN'S Dr. William Brainin NAME (Type) director, should b 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION, REMOVAL (Specify) Suitland, Maryland 7/25/67 Cedar Hill 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Pirth St. S.E. VR A15 (4) W.W.Chambers Co. Inc. Washington, D.C. 20 M 1/66



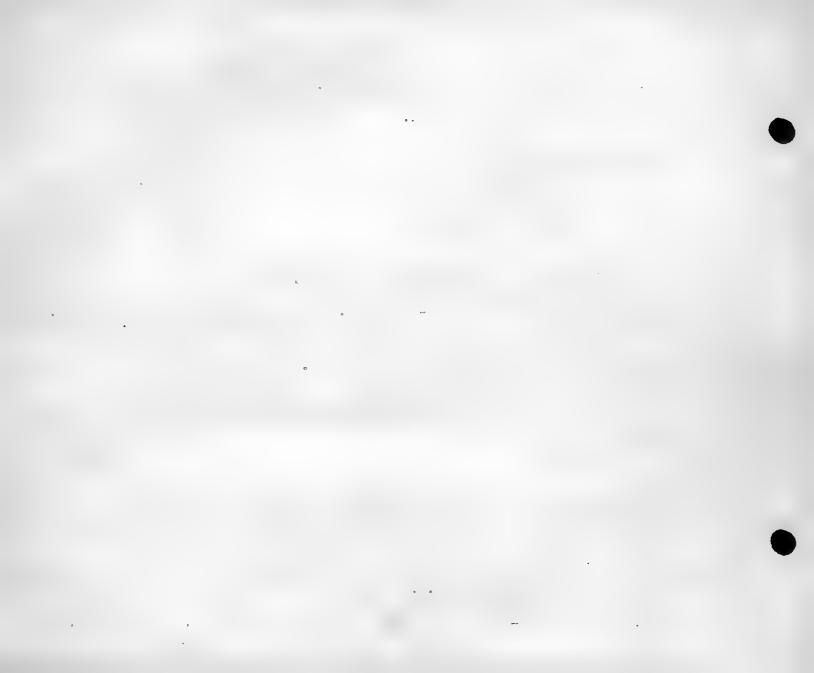
1/2 1	MARYLAND STATE DEPARTMENT OF HEALTH
	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	09785 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09785
HEALTH DEPT.	DESCRIPTION OF TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH OF STAY IN Ib   C CITY OR TOWN (If outside corporate higher)   C LENGTH
PM3 Per	Jakema Jak D. C.A. Fakenia Vark
th If ch ges 1, 2 form form	Tilish, San, & Harpital 8521 Dlonview ave, YES 10 NO
after death S. Give Page along with I	3 NAME OF DECEASED (Type or print) JOSEPH JOVES OF DEATH JULY 3/ 1967  5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years / IF UNDER 14 FIRST
	Mule negro WIDOWED DIVORCED 12-24-07 67 Months Days Hours Min
hin 24 haurs inc. In Item 18 niner's Office o pages land 2 v	during prost of working life, even it retired)  MAINTENANCE  GOOD ACRES  GEORGIA  GOUNTRY?
I within 24 no penc.l in Examiner's Examiner's F le pages 2 haurs affe	THOMAS JONES 14 MOTHER'S MAIDEN NAME THOMAS JONES Marke Henderson
be executed within "pending" in penc.l inef Med.cal Examine ansit permit. Fle pagent within 72 haurs	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dates of service).  16. SOCIAL SECURITY NO 17 INFORMANT Address
nould be executed word "pending" in the Chief Med.cal ra-fransit permit.	18 CAUSE OF DEATH (Enter only one couse per line of (a) (b) and (b) and (c) (c) and (c) (d) and (c) (d
should be e te word "per to the Chief I bur a-fransit	Conditions, if ony, which gove DUE TO Conservan Circles Heart Disperse
certificate shauld writing the word inwarded to the CF ised as a bura-traval, and in any ev	nse to immediate couse (o), stating the underlying couse (c)    lost
	PART .1 OTHER SIGNIFICANT CONDITIONS CONTR.BUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION G VEN IN PART 1(a)  19 WAS AUTOPSY PERFORMED? YES NO  20a EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURRED (Enter notifie of in any in Port 1 or Port 11 of term 18.)
뜨고 끝날	PRIMARY Or CONTRIBUTING C
	20c TIME OF INJURY Month, Doy, Year Hour a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, factory, street, office bldg, etc.) (Caunty) (State)
A Par Far Far Far Far Far Far Far Far Far F	21. I certify that I took charge of the remains described above, he did not Autopsy, Inspection, Inquiry, and in my opinion death resulted from Notural courses, Accident, Sucide, Homicide Undetermined manner
Mea pleas dire etair DIR	ACTUAL SIGNATURE OF CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 22 DATE SIGNED
o DEPUTY Inecessary, plane funeral of 5 may be reconstructed of Funeral Ineath pror	EXAMINER'S BELDEN R READIND ASSISTANCE COUNTY Soly 31, 1967
TO DEPU necessa the fun 5 may TO FUNE Health	230 BURIAL, CREMATION REMOVAL (Specify) 8-3-67 Carver Memorial Park Prince Georges County, Md.
VR A15ME (5)	24 FUNERAL DIRECTOR John T. Rhines Co ADDRESS 3015 12th 250 RECT BY REGISTRAR 256 REGISTRARS S. GMATURE Funeral Home Street, N. E. DATEAUG 7 1967 FUNCES June 1967



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09781 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY ~~ lont GomeRL MARYLAND y the f Pages/ b CITY OR TOWN (if outside corporate limits, re carboa papers. Pages e**vent** within 72 hours af c LENGTH OF STAY IN 16 outside carparate limits, write RURAL and give negrest town) write RURAL and give regrest town) 10000 9001 .⊆ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? filled i YES NO X NAME OF First Middle OATE remove carbon Lost Month Year **QECEASED** 19 (Type or pnnt) DEATH 6. COLOR OR RACE OATE OF BIRTH (In years 7. MARRIEO NEVER MARRIED birthdoy) Months Hours WIDOWED DIVORCED ar removal, ond in an gug 10a USUAL OCCUPATION (Give kind of work done 11. PIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) attending physician of sermit. Then please 1 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT "Old Down, Maine (Yes, no, or unknown) (If yes give wor or dotes of service Baillargeon Juneral Home 9-60-678 burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per lipe for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE fo Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gove rise to immediate cause (a). **DUE TO** stating the underlying couse this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. af Health prior to WAS AUTOPSY PERFORMED? PART II OTHER-SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT NO 200, ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (En) noture of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 3 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (Stote) 20c TIME OF INJURY Month, Doy, Year (City or town) (County) MED Hour to m. factory, street, office bldg., etc.) Not While ot work L TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 19 67, and that death occurred at 6:32 m. from cosses and saw the deceased olive on... on the date stated above. /220 SIGNATUR 22b. DATE SIGNED DIRECTOR M.D 22d ADDRESS 22c PHYSICIAN'S 230 BURIAL CREMATION 23b DATE THEREO 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Cemeteru FUNERAL DIRECTOR CONCEE LU 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09782 CERTIFICATE OF DEATH לים לי requires that the death certificate be executed within 24 hours after deoth the attending physician and completely filled in by the funeral sit permit. Then please remove corban papers. Pages A and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) O. COUNTY o. STATE Maryland b. COUNTY MARYLAND Montgomery b. CFTY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 oan papers. Pag within 72 hours Wheaton Silver Spring MO. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? University Nursing Home 2204 Washington Avenue YES NO X NAME OF Middle First 4 DATE Lost Month Dov Year DECEASED (Type or print) Tillie Kaufman 7-9 DODE DEATH 1967 S SEX 6. COLOR OR RACE 8 DATE OF BIRTH IF UNDER 1 YEAR 7 MARRIED 9. AGE (In years IF UNDER 24 HRS. **NEVER MARRIED** lost birthdoy) Months Dovs Hours ond in ony WIDOWED DIVORCED Female White /23/1896 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BiRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Housewife Russia USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremotion, or removal, Joseph Pecker Udel Abelman IS. WAS DECEASE. VER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Mr. Morris Kaufman-2204 Washington Ave. no 218-16-9049 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), INTERVAL BETWEEN signed by the buriol-tronsit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUF TO stating the underlying couse hos been Page 4 may be retained by the hospital or attending director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? ifter this certificate be detached for us YES [ NO 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Horne, form, (City or town) (County) (State) Hour o.m. While Not While foctory, street, office bldg, etc.) of work TO FUNERAL DIRECTOR: After ot work 21. I certify that (1) (this haspital) attended the deceased fram. . 19 4 7, to 4, 19 6 7 that (1) (we) last - W 10 19 6 7, and that death accurred at 932 M. Fram causes and an the date stated above. saw the deceased alive an. 22a SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. MD DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS 6056 Central Ave. (Seat Pleasant Capital Heights. Md. NAME (Type) William Brainin, M.D. Capitol Heights. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY --BURIAL, CREMATION. 23d LOCATION (City or Town) (County) (State) BuriaT National Capital Hebrew Cem. Washington. 7-10-67 ADDRESS WASHINGTON DE2SO. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 2Sb REGISTRAR'S SIGNATURE Milanta DATEJUL Namanella



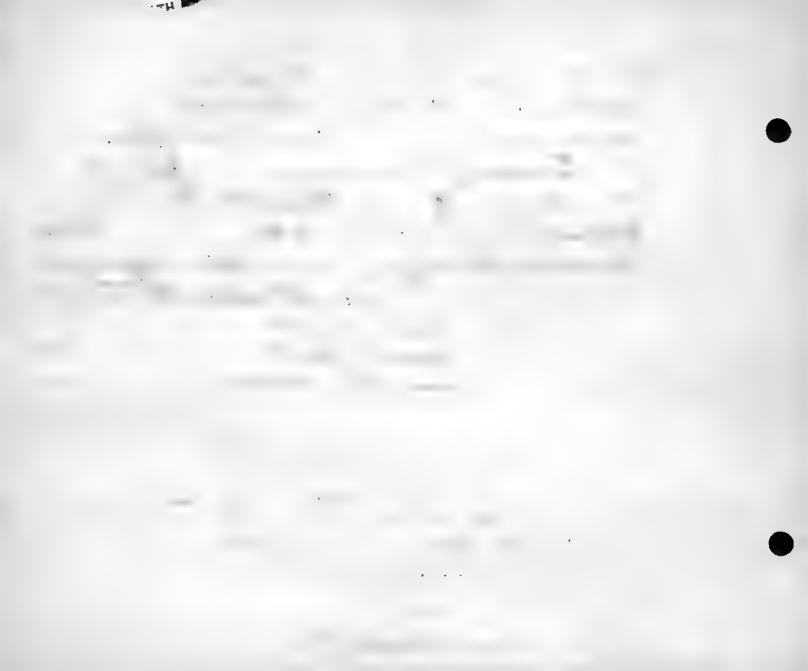
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 9783 requires that the death certificate be executed within 24 haurs after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. country a. STATE South Carolina MARYLAND **DEUNIERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely filled in by the foliatory page 3 should be detached far use as the burial-transit permit. Then please remave, confort appers. Pages should be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 12 haurs after b. CITY OR TOWN (if outside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corpgrate limits, write RURAL and give nearest town) Bethesda 46 Days Menriv Fark. Charleston (rural d NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? Naval Hospital 49 Webster Street NO Ty YES T. 3 NAME OF First 4. DATE Month Dov Year DECEASED July 1967 Janet Yvonne KERN 19 Type or print DFATH S SEX 6 COLOR OR RACE B. DATE OF BIRTH 9 AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED lost bethday) Months Female. Oct. 27,1963 Cauc. WIDOWED DIVORCED 10a LSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or fareign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Portsmouth. Virginia USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jackson R. Kern Helen Watson 17. INFORMANT Park. Charleston Address WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war or dates of service) N/A Jackson R. Kern. 49 Webster St., Menriv 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Acute leukemia with confluent bronchopneumonia Page 4 may be retained by the haspital ar attending physician. **DUE TO** Conditions, if any, which gove (b) rise ta îmmediote cause (a). DUE TO stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES THE NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20x TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (State) Not While factory, street, affice bldg , etc.) at wark at work 19 67, to July 19 , 1967, that M (we) last 2]. I certify that (this haspital) attended the deceased from June 7 saw the deceased olive an July 19 19, 67, and that death accurred at 64.5 MM, from causes and an the date stated obove. 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS X 20 July 1967 M.D. 22d ADDRESS 22c. PHYSICIAN'S J. I. LYNCH, M.D. NAME (Type) Naval Hospital, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g. BURIAL, CREMATION, 236 DATE THEREOF 7-22-67 (County) (Stote) REMOVAL (Specify) Cedar Hill Cemetery 0 Covington Virginia RAR ZSb. REGISTRAR'S SIGNATURE hobert A. Pumphrey Funeral Home 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Willander Judges 7557 Wisconsin Ave. Bethesda, Md.



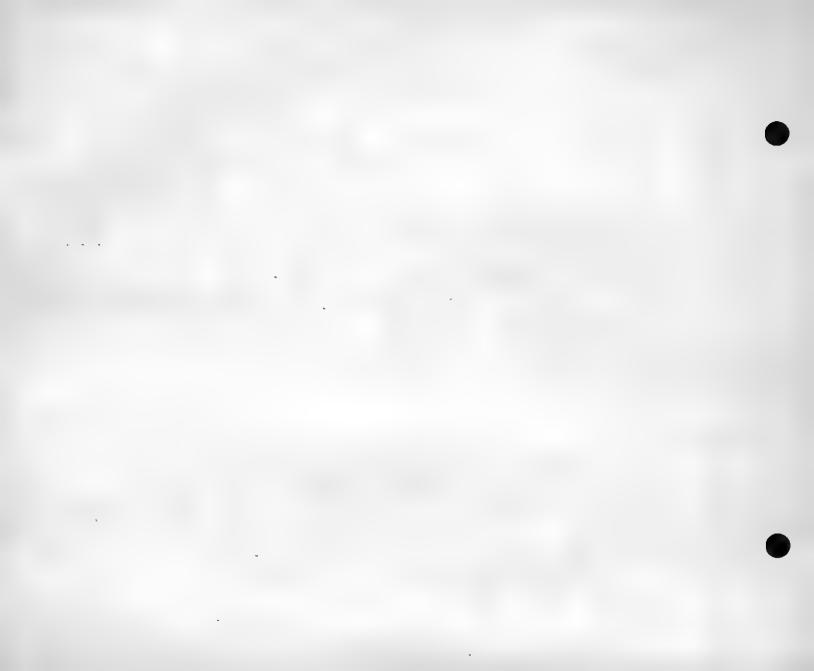
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0078. 69208 CERTIFICATE OF DEATH death. funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before odmission) o. COUNTY b. COUNTY MARYIAND RGINIA b. CITY OR TOWN-(If outside corporate limits, c. LENGTH OF STAY IN 1b. c, CITY OR TOWN (If outside comparate limits, write RURAL and give negrest town). Prite RURAL and give nearest town) AYS DO NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE d. STREET ADDRESS ON A FARM? requires that the death certificate be executed within 24 NO X YES 3. NAME OF Middle 4 DATE Doy Year DECEASED
(Type or print) OF DEATH Y-awent, 19 LLITELMINA TE LINDER I YEAR IF LINDER 24 HRS S. SEX 6 COLOR OR RACE AGE (In years 7. MARRIED DATE OF NEVER MARRIED birthdoy) Months Hours WIDOWED DIVORCED puo 10o US WAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) .≘ during most of working life, even if retired) INDUSTRY COUNTRY? attending physician sermit. Then please HOUSELL DOKLY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotian, or removal, Address 2540 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service TUKNOLDN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN by the signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or ottending physician DUE TO Conditions, if ony, which gove use to immediate couse (a). DUE TO for use as the t Health priar to b stoting the underlying couse hos been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO. certificate 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING 🗀 CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Dov. Year (City or town) (County) (State) Hour om. foctory, street, office bldg , etc ) While Not While FUNIRAL DIRECTOR: After at work 21. I certify that (I) (this haspital) attended the deceased from 19 ( ), that (I) (we) last and that death accurred at 150 PM, from causes and an the date stated above saw the deceased alive an 19.3 220. SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR M.D. PHYS. PHYS. director, page should be filed 22c. PHYSICIAN'S ADDRESS NAME (Type) IOCATION (City or Town) 23b. DATE THEREOF (State) BURIAL, CREMAT ON. 23€ (County) REMOVAL (Specify) Terrial FUNERAL DIRECTOR AD DRES 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALT. DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 00785 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, It institution; Residence before admission) a COUNTY b. COUNTY by the MARYLAND b. CITY DR TOWN OR outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY DR TDWOL if outside corporate limits, write RURAL and give nearest town) papers, rewrite RURAL and give nearest toyer) .= filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? θ. Within 72 YES NO D executed within completely event, with NAME DE 3. First Middle DATE Month Last Day Year DECEASED DEATH (Type or print) 194 ABE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. ast birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR DR RACE DAL 7. MARBIED NEVER MARRIED rsician and clease remorand WIDOWED D DIVORCED attending physician a ermit. Then please re on, or removal, and in a 10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN DF WHAT 11. BIRTHPLACE (County & State. or foreign country) that the death certificate be MIDUSTRY COUNTRY? ler FATHER'S NAME MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. 17. INFORMANT the burial-transit permit. (Yes, no, or ankown) ((If yes give war or dates of service) the CAUSE OF DEATH [Enter only one cause per line for (a), INVERVAL BETWEEN ONSET AND DEATH (b), and (c), signed by PART I, DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ti Page 4 may be retained by the hospital or attending physician. CLI Miper Co IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) to FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the b should be filed with the State Dept. of Health prior to b gave rise to Immediate DUE TO cause (a), stating the underlying cause last. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPS 19. PERFORMED? CERTIFICAT YES X ND 2Da. ACCIDENT WAS UNDERLYING DE CONTRIBUTING CAUSE DE DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While 19 at work p.m. at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 7/3 saw the deceased alive on \_M, from the causes and on the date stated above. 22a, SIGNATURE 22b. DATE SIGNED MÉD. ATTENDING PHYS. STAFF M.D. DIRECTOR PHYS. PHYSICIAN'S 22d. ADDRESS NAME (Type) DATE THEREO (State) BURIAL, CREMATION, 23b. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) 23a. REMOVAL (Specify) **ADDRESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a. VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09730 09786 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b COUNTY Montsomeru Montcomerc maruland PHYSICIAN: The law requires that the death certificate be executed within 24 hours after MARYLAND b. CITY OR TOWN (If outside carparate limits.) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Silver Sprins Rockville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Cross NOS Dital 900 Rockinghorse NO PO NAME OF First Middle Last DATE Doy Year DECEASED OF 0 Rinc lice 19 67 Type or print) DEATH SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR JE UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED **NEVER MARRIED** lost birthdoy) Months remov Hours Female white 10/03 cremotion, or removol, and in any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & Stote, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even in retired) nurse LOUNTRY . China 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME E. Wood Gere Shipley WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO 11900 Rocking Horse Road permit. (Yes, no, or unknown) (If yes give wor or dotes of service 232-62-1708 Mrs. Lenora Few None 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (s)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH signed by the buriol-transit p IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physicion. DUE TO buriol. Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO prior to stoting the underlying couse os the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D.SEASE COND TION GIVEN IN PART 1(a) 19 WAS AUTOPS'
PERFORMED? YES F NO this certificate 20g. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c, TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) of work of work 21. I certify that (1) (this hospital) attended the deceased from Tran 21 , 1966, to greke 14 1925, that (1) (-we) last 1967, and that death accurred at 11.100 M, from douses and an the date stated above. FUNERAL DIRECTOR: saw the deceased alive an. 22a SIGNATURI 22b. DATE SIGNED DIRECTOR director, page should be filed M D 22d, ADDRESS 22c. PHYSICIAN NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23d LOCATION REMOVAL (Specify) 1967 Moreland Memorial Park Baltimore, Maryland 16 REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE Georgia Avenue VR A15 (4) 25M 1/67



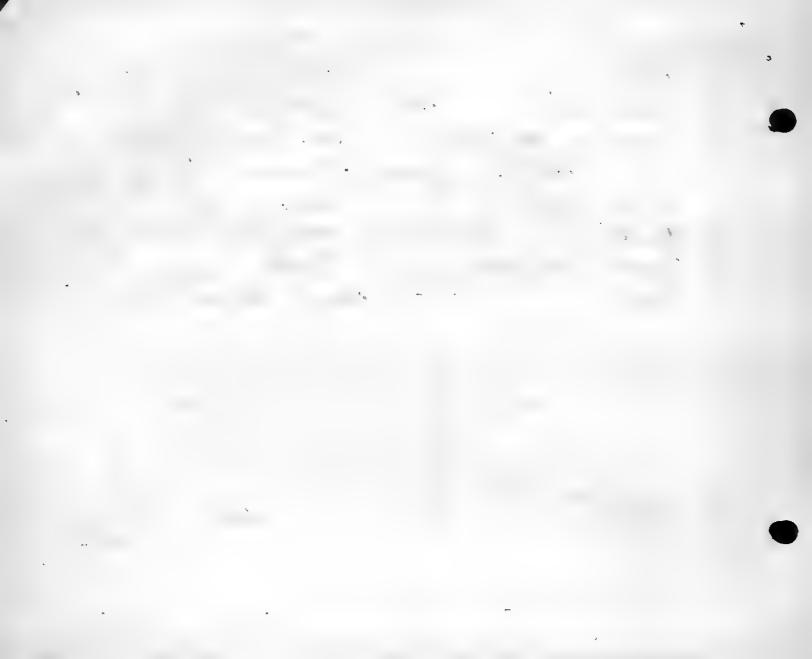
* 1	Ite is 1 & 21. "Im #33 MARYLAND STATE DEPARTMENT OF HEALTH    1	
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	2
HEALTH DEPT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived first haten Residence before a stationary maryland b COUNTY and down	idmiss on)
deloy ond 3	b. CHT OR TOWN (If outside corporate limits telepath of STAY IN 16 c CITY OF TOWN HOUSE Corporate limits, write RURAL and give parest town)  2 months  CONTROL OF STAY IN 16  CONTROL O	T
ges 1, 2 form form ate Dep	Holy Cross Hospital 10163 Sutherland Kil	S RESIDENCE ONC A FARM?
ive Pooring with	3 NAME OF DECEASED First Middle KIRBY OF DEATH 7-28	19 6 7 F UNDER 24 HRS
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thin 24 hours incil in Item 1 miner's Office pages 1 and 2 urs offer deoth	10a. USUAL OCCUPATION (G ve kind of work core during most of work core during most of working sta, even if retired); Cectricinous RY Naval Gun Factory Maryland (Contrary)	S.A.
within pencil xomine ile pag	John J. Kirly and mc GANN	
xecuted with range in per Medical Exor permit. File with n 72 hou	15 WASKICEASED EVER IN U.S. ARMEDIORCES?  16 SOCIAL SEGERITY NO  17 INFORMANT  18 WASKICEASED EVER IN U.S. ARMEDIORCES?  18 SOCIAL SEGERITY NO  18 INFORMANT  18 SOCIAL SEGERITY NO  18	Md
	PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of Colin	AL BETWEEN AND DEATH
he word "per to the Chief" buriol-tronsit	Conditions, if any, which gave (b)  Tise to immediate cause (a), DUE TO	
iting the integrated and it ond it	lost. (c)	AC AUTODOV
his certinote, writh the forward be used emoval,	Š YES	AS AUTOPSY REORMED?
UNER: The certifico should be files. 3 should to files.		
TO DEPUTY MEDICAL EXAMINER: necessory, please execute the cert the funeral director. Page 4 should 5 may be retained far your files. To FUNERAL DIRECTOR: Page 3 should Health prior to burial, cremation, or	20c TIME OF INJURY Manth, Day Year Hour a m p m 19 20d INJURY OCCURRED 20e PLACE OF NJURY (Hame, farm, factory, street, affice b dg etc.)  20d INJURY Manth, Day Year While Nor While at work at work	(State)
DEPUTY MEDICAL EXAM seessory, please execute the funeral director. Page 4 may be retained for your FUNERAL DIRECTOR: Page eoith prior to burial, crema	death resulted from Natural causes 🔼 , Accident 🗍 Suicide 🗍 , Hamic de 🗍 , Undefermined manner 🗍	n my opinion
O DEPUTY MEDICA The funeral director.	SIGNATURE MD ASS STANT MEDICAL EXAMINER L	DATE SIGNED
O DEPUTY necessory, the funeral 5 may be 0 FUNERAL Heolth pric	EXAMINER'S BELDEN POPULATION, 23b. DATE THEREOF 23c NAME OF CEMINERY OF CREMATORY 23d LOCATION (City or John) (County)	967 (State)
101 101 101 101	Burnal (Specify) Aug J. 1967, Mt. Olivet Cemetery Washington, D. C.	(2,0,6)
VR A15ME (5) 6M 1/67	Warner E. Pumphrey, Inc. Silver Spring Md. DATE AUG 1 1967 GUICENERS SIGNATURE	noge



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09793 09788 CERTIFICATE OF DEATH The faw requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) **b** COUNTY MARYLAND LENGTH OF STAY IN 16 b. CITY OR FOWN (If autside corporate limits, c CITY OR TOWN (If ours, de-corporate limits, write RURAL and give nearest town) and give hearest lawn) d NAME OF HOSPITAL OR, INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS papers. IS RESIDENC hin 72 ON A FARM? YES NO X carban ent, with 3. NAME OF Middle 4. DATE Lost Month completely DECEASED (Type or print) DEATH 5. SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR 7. MARRIED **NEVER MARRIED** DATE/OF BIRTH birthdoy) Months Doys Haurs WIDOWED DIVORCED pup rem 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY 14 MATHER'S MAIDEN NAME 13. FATHER & NAME ar removal, the attending parties of the IS. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service) 17, INFORMANT 16. SOCIAL SECURITY NO. Rockvillemo signed by the atter bur al-transit perm burial, crematian, a 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO r this certificate has been si detached far use as the b te llept =f Health prior ta b stating the underlying couse Page 4 may be retained by the haspital or attending 19. WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT-NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/6) NO OR ATTENDING PHYSICIAN: 200 ACCIDENT WAS UNDERTYING [ 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18 OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF NURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) Haur a.m. Not While factory, street, affice blda., etc.) 19 Affer at wark L at work 2]. I certify that (1) (this haspital) attended the deceased fram TO FUNERAL DIRECTOR: 64 M, fram causes and an the date stated above saw the deceased alive an and that death accurred at 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS director, page shauld be filed 22c PHYSICIAN S 22d NAME (Type) NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, 235 DATE THEREOF 230 LOCATION REMOVAL (Specify) FUNE LAL DIRECTOR VR A15 (4) 25M 1/67



	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-
7.	09789 CERTIFICATE OF DEATH
E g	1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fived, if institution, Residence before admission)
	Maryland Mareland Mortanice
	b CITY OR LOSA (If guisside comparate limits C. LENGTH OF STAY IN 1b C CITY OR TOWN (If guisside comparate limits write R-IRA) and give neares flown)
	De the da Bethisda
	d NAME OF HOSP TAL OR INSTITUTION (U not in haspital, give street oddress)  Superburban Hospital 912 Colon St. act A YES NO NO
1	3 NAME OF FirstMiddleodt4 DATEMonthDay Year
i	(Type or print) JAMES G. KREMER DEATH July 26 1967
	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF B.RTH 9. AGE to years 1 FUNDER 1 YEAR 1 FUNDER 24 HRS
	MG/E White WIDOWED DIVORCED MAR 23, 1903 64 yrs.
	10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	Bus Driver D. C. Harat Mr. aug maybe USA.
	13 FATHER'S NAME  14. MOTHER'S MANGEN NAME  TOCKER. RHODA
١	
	(Ye no, or unknown) (If yes give wor or dotes of services 78-10-5423 Mary T. Kreiner - wife)
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  INTERVAL BETWEEN
	PART I, DEATH WAS CAUSED BY: CORRELATION ONSET, AND DEATH
	IMMEDIATE CAUSE (a)  DUE TO
	Conditions, it ony, which gove ) (b) HYPERTENSIVE HEAR OISEASE, 10 YR)
	rise to immediate cause (a), stating the underlying cause DUE TO
	last. (c)
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  19. WAS AUTOPSY PERFORMED?
	YES NO I
	PERFORMED?  YES NO 1  200 ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  PERFORMED?  YES NO 1  YES NO 1
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, Hour o.m., While Not While State)
	p.m. arwark 🗀 arwark 🗀
	21. I certify that (I) (this haspital) attended the deceased fram TAY, 1953, ta TOLY, 1967, that (I) (we) last saw the deceased alive on TOLY 1967, and that death accurred at 1970M, from causes and on the date stated above.
	saw the deceased alive on 19 C7, and that death accurred unique, from causes and on the date stated above.  220. SIGNATURE 22b DATE SCINED
	M.D. PHYS DIRECTOR DIRECTOR TO PHYS. To 7-26-67
	22c PHYSICIANS DR 45 g T DONG VA 22d ADDRESS
	NAME (Type) PAR BETHELDER
	230 BURIAL (REMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State)
	Burra (arm) 7-29-67 Gate of Heaven Cem. Silver Spring, Maryland
	24 FUNERAL DIRECTOR  ROBERT A PHIMPHREY Bethesda Maryland 1111 9 8 1967 Charles Index



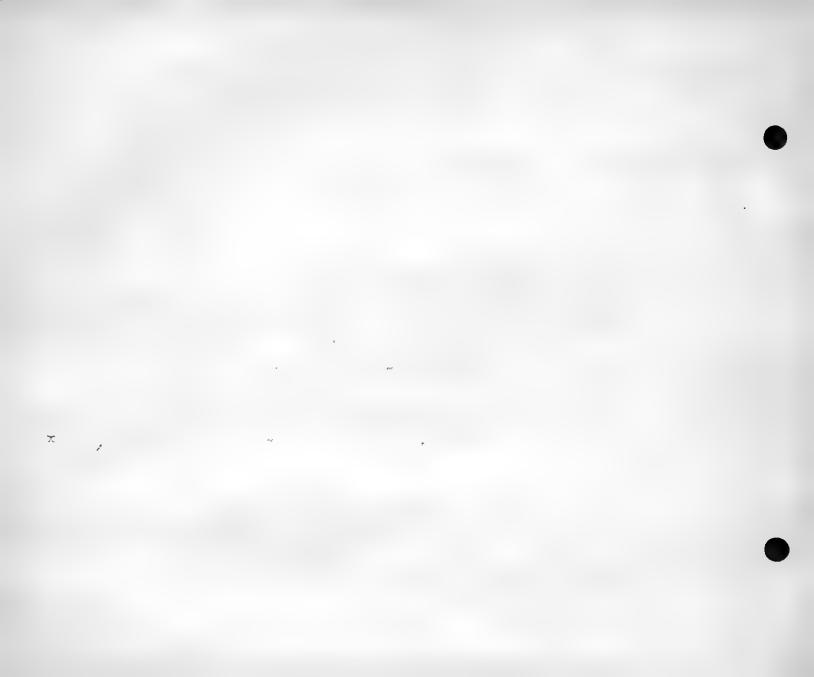
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09786 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH · COUNTY Montgomery o STATE District of Columbia MARY, AND b (IY OR IOWN (if outs de corporote l'mis, write R. RAI ond give neorest town) Bethesda (rural) c LENGTH OF STAY IN 16 c C TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2, and PM3 F 55 days Washington 601 d NAME OF HOSPITAL OR ASTITUT ON (If not in hospital, give street address) d STREET ADDRESS e IS RES DENC ON A FARMS please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, I arrector Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm 1841 Columbia Road, N.W. Apt. Naval Hospital NO CX NAME OF M ddle 4 DATE OF DEATH DECEASED 19 67 KULBERG July Susan Olive (Type or print) IF UNDER 1 YEAR NEVER MARR ED 30% 8. DATE OF B RTH 9 AGE (In years 6 COLOR OR RACE 7 MARRIED [ birthdoy) Nov. 12, 1949 Cauc WIDOWED D VORCED Female 100 USUA, OCCUPATION (Give kind of work done 11 BiRTHPLACE (State or foreign country) 10b K ND OF BUSINESS OR 2 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY USA Bradford, Massachusetts 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Mellicent McLagan Harry O. Kulberg N.W. Apt. 601 Address Wash. D.C. 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOE AL SECUR TY NO (Yes, no, or unknown) (I fives a ve wor or dates of service) Mr. Harry O. Kulberg, 1841 Columbia Rd. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bronchial Pneumonia This certificate should Conditions if any which gove ) 74 days (b) Anoxic encephalopathy rise to immediate couse (a) DUE TO stoting the underlying couse 74 days (c) Respiratory arrest PART II OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? YES K NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of Item 18.) PRIMARY DECOL CONTRIBUTING Over dose of Darvon 20e PLACE OF NJURY (Home, form, 20f (City or town) (County) 20rd N.J.RY OCCURRED (Stote) 20c TIME OF INJURY Month, Doy Year While Not While of work of work xx L May 1967 Washington D.C. 21. I certify that I took charge of the remains described above held on Autopsy , Inspection , nquiry , and in my opinion death resulted from. Notyrol couses , Accident , Suicide X, Homicide Undetermined monner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASS STANT MEDICAL EXAMINER SIGNATURE 7-15-67 DEPUTY MED CA. EXAM NER **EXAMINER'S** Address (Street, cly, town or county) Bethesda. Md. John G. BALL 234 NAME OF TEMETERY OR TREMATORY 23d LOCATION (City or Town) (Fronty) (State) 23b DATE THEREOF 230 BURIAL PREMATION 7-18-67 Arlington National Arlington, Virginia 250 RECD BY REGISTRAR 25B REGISTRARS SIGNATURE 24 FUNERAL D RECTOR Robert A. Pumphrey Funeral Home VR A15ME (5) Wisconsin Ave., Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) C LENGTH OF STAY IN 16 Silver Spring NYTITUTION (If not in hospital, give street address) d. STREET ADDRESS First DATE Year DECEASED OF DEATH and in any event AGE { n years SEX 7. MARRIED NEVER MARRIED Jost bushdoy) remaye Months Days WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT 1Do. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) Rouse INDUSTRY MOTHER'S MAIDEN NAME FATHER S NAME ar remayal. Charles Fachle Louise Hageman IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT LOIAddress Tenbrook Drive (Yes, no, or unknown) [(If yes give wor or dates of service) Silver Spring Mrs. Oliver 9. Judge 196-38-1189 crematian, 18. CAUSE OF DEATH (Enter only one couse per lipe-(or (o), (b), and (c).) INTERVAL BEDWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying couse **DIRECTOR:** After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTTON RELATED TO THE TERMINAL DISEASE CONDITION GIVEN AS PART 1(6) WAS AUTOPSY PERFORMED? use NO 200 ACCIDENT WAS UNDERLYING (Enter noture of injury in Parts or Port 10 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, foctory, street, office bldg, etc.) 2Dd "INJURY OCCURRED 2Df. (Eity or town) (County) (State) Not While 21. I certify that (1) (this haspital) attended the deceased from , 196 (that (I) (we) last ond that death occurred at B.M., frag causes and on the date stated above. sow the deceased alive on 220 SIGNATUR 22b. DATE SIGNED ATTENDING PHYS. directar, page 3 should be filed v DIRECTOR M.D. 22c PHYSICIAN'S 22d. ADDRESS O FUNERAL NAME (Type) 230 BURIAL, CREMATION, 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) Printaine Cometery Liegraia VR A15 (4) 25M 1/67 arner L. Primmhren.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09792 CERTIFICATE OF DEATH death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY MONTGOMERY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after MARYLAND MONTGOMERY b CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 15 TESDA d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 2304 YES NO DC NAME OF First Middle Lost DATE Year DECEASED OF (Type or pant) NCASTER DEATH 19 67 6. COLOR OR RACE WARRIED B. DATE OF BIRTH IF JNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED AGE (In years ost birthday) Months Dovs Hours Min rema WIDOWED DIVORCED NEGRO MALE 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 SIRTHPLACE (County & Stote or foreign country) 12 CIT ZEN OF WHAT during most of working ife, even if retired) INDUSTRY COUNTRY? MARYLAND NURSERY WORK 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) SAME crematian, INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Coronary insufficiency 24 hours by the haspital or attending physician. DUE TO Coronary arteriosclerosis Conditions, if any, which gave years rise to immediate couse (a), DUE TO stoting the underlying couse has been last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? Primary cholangio-carcinoma, left lobe of liver YES 📆 NO certificate 2Do ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stota) ((ounty) foctory, street, office bldg . etc.) of work of work 21. 1 certify that\_(I) (this haspital) attended the deceased fram , 19\_\_\_, that (I) (we) las . to be retained , and that death accurred at OWAM, fram causes and an the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an 22o SIGNATURE 22b. DATE SIGNED M.D DIRECTOR r, page be filed 22c. PHYSICIAN 22d. ADDRESS NAME (Type) director, I BURIAL, CREMATION 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) ((ounty) (Stote) REMOVAL (Specify) 24) FUNERAL DIRECTOR 2So REC'D BY REGISTRAR VR A15 (4) 25M 1/67



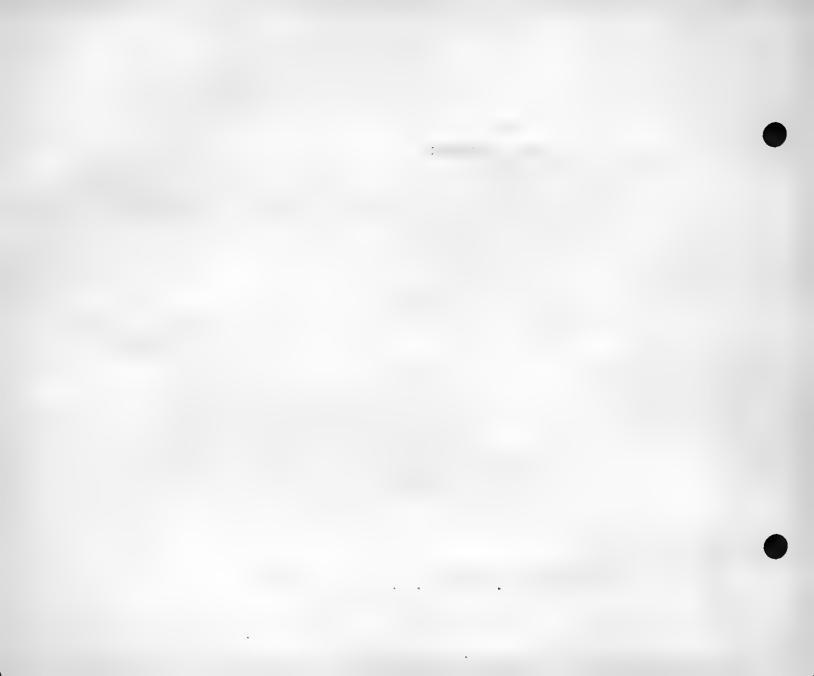
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased leved, if institution Residence before admission) e COUNTY b. COUNTY ety filled in by the fund ban papers. Pages 1 of ynthin 72 haurs affer ty MONTGOMERY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 write RURAL and gure nearest fown! Dina PLAINS TAKOMA MARK d NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) e IS RESIDENCE ON A FARM? SAKITARIUM YES NO K pou NAME OF 4 DATE Middle Молт Dov Year DECEASED **OF** LANGDOM Type or print) LOVINA DFATH 967 SEX 6 COLOR OR RACE MARRIED 9 AGE (lp years lost bithday) IF LINDER 24 HRS NEVER MARRIFO B. DATE OF BIRTH Months Hours W WIDOWED S DIVORCED rer 12 CIT ZEN OF WHAT IDo USUA, OCCUPATION (Give kind of work done TOO KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) attending physician iermit. Then please dering most of working ite, even if retired) INDUSTRY COUNTRY? I Own home 13. FATHER S NAME 14. MOTHER'S MAIDEN NAM crematian, ar remaval, HOWARD WILLIAM WAS DECEASED EVER IN U.S. ARMED FORCES? e DS Silver Spring, Md 16 SOCIAL SECURITY NO **INFORMANT** (Yes, pg, or unknown) (If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one couse per fine for (a), (b), and (c) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immed ate couse (a). DUE TO stoting the underlying couse as the b last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS ALTOPS! be detached for use State Dept, of Health De recete. NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om foctory street, office pldg.etc.) at work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased fram be retained director, page 3 shauld shauld be filed with the saw the deceased alive an. and that death accurred at 7.55 A.M. fram causes and an the date stated obove. 220. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22c. PHYS CIAN'S 22d ADDRESS Page 4 may NAME (Type) 230 BUR AL, CREMAT ON, DATE AGEREOF 23c NAME OF CEMETERY OR CREMATORY 236 LOCATION (City or Town) (Stote) REMOVAL (Specify) Fort Lincoln Crematory Prince Georges Maryland 2So. REC'D BY REGISTRAR 2Sb REGISTRAR S S GNATURE VR A15 (4) 25M 1/III



MARYLAND STATE DEPARTMENT OF HEALTH 00799 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

	CERTIFICAT	E OF DEATH
1	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceosed lived, if institut an Residence before admission)
	O. COUNTY MARYLAND	MARYLAND MONTGOMERY
-	b CITY OR TOWN (If gutside corporate limits.	c CITY OR YOWN (If outs de carporole limits, write RURAL and give neorest (awn)
	WILL RURAL and give nearest town)  13ETESDA  15 1/2 URS.	SILVER SPRING
	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitat, give street address)	d STREET ADDRESS
	SUBURBAN Hospital	1514 Live OAK DRIVE YES NO
3.	NAME OF First Middle	Last 4 DATE Manth Day Year
П	PECEASED (Type or print)  Emily  Kane	LAST DEATH July 23 196
5	SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED	B DATE OF BIRTH 8/23/12 9 AGE (In years / IF UNDER 1 YEAR   IF UNDER 24   In years   Maritis   Days   Hours   N
	EMALE WHITE WIDOWED DIVORCED	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
10	o USUAL OCCUPAT ON (Give kind of work done light with the street l	11. BIRTHP ACE (County & Stote, or foreign country)  12. CITIZEN OF WHAT COUNTRY?
	HOUSEWIFE Own home	PENNA U.S.A
13	3. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	FELIX KANE	Emily Dugan
15	(as no art plantum) (If was now war of dates of senura)	. INFORMANT Address
1,"	(es, no, grunknown) (If jugs give war or dates of service) 577-18-1952	PAUL V. LAST - HUSBAND - SAME
	TB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEE
	PART : DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CENTO- La la	ul Myrcardol (Marchen 37 /
	Travel DUE TO	1 /20 0 1 2/1
	Conditions, if ony, which gave rise to immediate cause (a),	any theory oses I he
	stoling the underlying cause DUE TO	1 x 11 V 1 argent
	lost. (c) Consultation	and Desor
8	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19 WAS A TOPSY PERFORMED?
B		YES NO
MEDICAL CERTIFICATION	200 ACC DENT WAS UNDERLYING  OR CONTRIBUTING  (IF EITHER, NOTIFY MEDICAL EXAMINER)	D (Enter nature of injury in Part II or Part II of item IB)
1	(IF EITHER, NOTIFY MEDICAL EXAMINER)	
EDIC	20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e P	LACE OF INJURY (Hame, Farm, 20f (City or tawn) (County) (Statestrony, street, office bldg_etc.)
Z	p.m. 19 at work ot work	
	21. I certify that (I) (this haspital) attended the deceased fram_	
		of death accurred at 0534M, from causes and an the date stated at
	220 SIGNATURE A TILL A	M.D ATTENDING MED. STAFF 226. DATE SIGNED DIRECTOR PHYS. 226. DATE SIGNED
		M.D. PHYS DIRECTOR DIRECTOR PHYS. 300/46
	221 MISCIAN'S NAME (Type) Merton L. White, M. D.	9911 Leongin Ave Cilver On
20	30 BUR A. CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY O	R CREMATORY 23d LOCATION (City or Town) (County) (Slote
# Z.	OU DUR A. CREINATION. I ZOU D'AIT IMERCUT I ZOU NAME UT CEMITIER? U	K CKEMINION   ZOU LOCKHON [CITY OF TOWN! (COUNTY) (STORE

July 26, 1967 Gate of Heaven Cemetery Silver Spring, Mary and 250 RECOUNTY Shows 8434 ADDRESS AGENT AREA SHOWN AND HELD BY REGISTRAN 967 256 REGISTRANS HONATURE AND THE DATE OF THE STREET OF THE PROPERTY OF



1	1	O D D D DIVISION OF	MARYLAND STATE DEPA VITAL RECORDS, 301 W. PRESTO		AND 21201	
(14)		09795 DIVISION OF	CERTIFICATE	OF DEATH	6930	0
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. De retained by the haspital at attending physician.  SIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the fungral should be detached for use as the burial-transit permit. Then please remove carban papers. Pages I and sed with the State Dept. of Realth priar to burial, cremation, ar removal, and in any event, within 72 hours after death.		LACE OF DEATH  COUNTY  OUT A C	MARYLAND  C LENGTH OF STAY IN 16  75 days on hospitol, give street oddress)	mary and	inved, if institution: Residence before of b. COUNTY AND COUNTY AN	wn) RESIDENCE N A FARM?
ecuted within campletely fill ove carban py event, within		IAME OF First JECEASED Type or print)  EX  6. COLOR OR RACE  7		Cutman DATE OF DEATH DATE OF BIRTH  9		Year 19 6 7 UNDER 24 HRS
icate be executed within 24 h. sistian and campletely filled in please remove carban_papers, ond in any event, wmin 724,	10c dur	USUAL OCCUPATION (Give kind of work done and most of working life, even if returned)	WIDOWED DIVORCED DIVORCED TOOL KIND OF BUSINESS OR INDUSTRY	Sept. 4 1890 1 11. BIRTHPLACE (County & Stote or Fore) Austria	16 yis	HAT
ertifica physic hen ple naval, c	13.	FATHER'S NAME		14. MOTHER'S MAIDEN NAME  CELIA	STISTEL	
e death certificate t attending physician permit. Then please an, ar remaval, and i	15 (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? , no, ar unknown) (If yes give wor or dotes of s	ervice)	NFORMANT rs. Anita Bickford	Address 6409 E. H Bethesda, Md.	albert
<b>G PHYSICIAN:</b> The law requires that the death certificate haspital or attending physician. This certificate has been signed by the attending phydetached for use as the burial-transit permit. Then the Dept. of Health priar ta burial, crematian, ar remayal		18 CAUSE OF DEATH (Enter on y one couse PART I DEATH WAS CAUSED BY.  23 1/X IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which gove rise to immediate cause (o), storing the underlying couse lost.	(ene brovascul	ar anterioode	NSST ONSST	AL BETWEEN AND DEATH
IAN: The law ratending all ar attending iiate has been for use as the Health priar ta	FICATION		ATRIBUTING TO DEATH BUT NOT RELAXED TO THE	THE TERMINAL D SEASE CONDIT ON GIVEN	IN PART 1(0) 19 WA PER 145 [	IS AUTOPSY REFORMED?
rsician aspital c certificat hed for	CERT	20g ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CONTRIBUTION	206 DESCRIBE HOW INJURY OCCURRED.			
DING PHYSICIAN: The law re I by the haspital ar attending After this certificate has been I be detached for use as the State Dept. of Health priar ta	MEDICAL	20c TIME OF IN. JRY Month, Day, Year Hour om p.m. 19	20d INJURY OCCURRED 20e PLAN White of work of work of work  1al) attended the deceased fram	ory, street, office bldg , etc )	City or town) (County)	(Stote)
TO HOSPITAL OR ATTENDING PHYSICI Page 4 may be retained by the haspiti TO FUNERAL DIRECTOR: After this certif director, page 3 should be detached should be filed with the State Dept. of		saw the deceased alive an 220. SIGNATURE	C. Sali MD	death accurred at 12 4M,	from casses and an the date s  22b DATE SIGNED PHYS 7/7/6	tated abave
PITAL O may be ERAL DIR ir, page		22c. PHYSICIAN'S HAROL	D C. SADIN M.	) 22d ADDRESS K. S	+. N.W. WASHIN	UGBN DC
TO HOSI Page 4 TO FUNE directo should		BUR AL (CREMAT ON, REMOVAL (Specify) 7/18/(	67 Mount Hebron		TON (City or Town) (County)  ring, Long Island,	(Stote) N.W.
VR A15 (4) 25M 1/67	1	FUNERAL DIRECTOR Donald M.	*	D.C. DATAL 19 196	7 St. REGISTRARS SIGNATURE	pe



	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
7		09796		OF DEATH	09891
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nin 24 hours after d filled in by the fun- papers. Pages 1 phin 72 hours after d		CITY OR TOWN (If autistic carparate limits, write RURAL and give nearest tawn)     NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street)	et address	c CITY OR TOWN (If outside carparate limits, write RURAL and g  But f Thew York  d STREET ADDRESS	,
filled in 24 I him 72 thin 72	(2	andoeps Diel Numaing Home 40	11 Oonbert	( 35Ea+208 44	e. IS RESIDENCE ON A FARM? YES NO
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e executed vand complete	5	male 6 color or race 7 Married 1	NEVER MARRIED   B DIVORCED   2	4/ 15/ 1885   lost b thaay)   Months	
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ie death certifi attending phy permit. Then ian, ar remava		WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL S  (If yes give war or dates af service)	SECURITY NO. 17. IN	rold Leruer, Son - Rockerll	wer Dewe
equires that the physician. signed by the burial-transit burial, cremat		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (c)	brel (	arterioseleroses	INTERVAL BETWEEN ONSET AND DEATH
The law re ratending by has been use as the lith prior to	CATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH	BUT NOT RELATED TO TH	HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
Page 4 may be retained by the haspital or attending To FUNERAL DIRECTOR: After this certificate has been directar, page 3 should be detached far use as the should be filed with the State Dept. af Health prior to	CERTIF.	20g ACCIDENT WAS UNDERLYING TO OF CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	·	Enter nature of injury in Part I or Part II of Item 1B.)	
NING PHYSICIA by the haspital ffer this certifice be detached fa State Dept. af H	MEDICAL	p.m. 19 otwark 🔲 i	lat While factor of work	ry, street, affice bldg , etc.)	County) (Stote)
ATTENDING stained by th CTOR: After t should be d		21. I certify that (I) (this haspital) attended th saw the deceased alive an	e deceased fram _19_ <u>62</u> , and that	death accurred at 4: 334M, fram causes and an	
OR ATTEND be retained bolrector: A pe 3 should led with the		220 SIGNATURE Orymond T. Ben	ack M.D.	ATTENDING AND STAFF COLUMN	DATE SIGNED  5 7 7
TO HOSPITAL ( Page 4 may b TO FUNERAL DI directar, page should be file		12c. PHYSICIANS NAME (Type) RAY mond T. BE	NACK MI	0 4/15 Colie DRIVE,	wheaton mo
TO HO Page TO FUN direct shauj	23	Burial 7/7/67 RC	NAME OF CEMETERY OR CI	REMAJORY 23d LOCATION (City or Town) Brooklyn, U	(County) (State)
VR A15 (4) 20 M 1/66	2	B Dansansky + Some	3501-14	La St. RECT. BY REGISTRAR 19676. REGISTRAR	Erles Judge



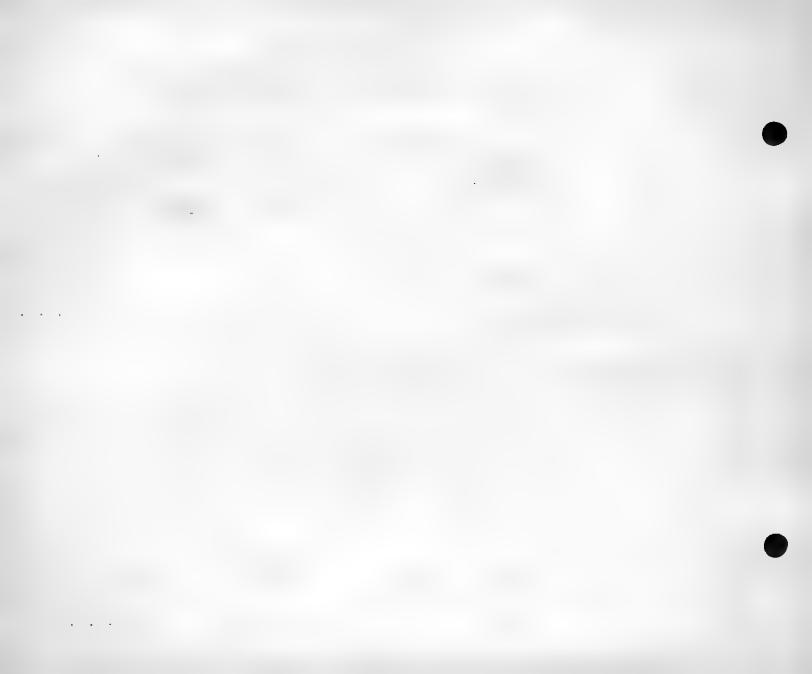
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2 USUAL RESIDENCE Mahre de ved of institution Residence before admission) p. COUNTY within 72 hours after MARYLAND Pages n ts, write RURAs and give nearest town) b. CITY OR TOWN (If dutside corporate I mil c. LENGTH OF STAY IN 16 .⊆ n haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? capabletely filled YES NO T NAME OF DATE Month Year DECEASED 1967 (Type or pont) Le DEATH 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR MARRIED **NEVER MARRIED** B DATE OF BURTH IF UNDER 24 HRS e e iast birthday) Months Days Haurs remai crematian, or remayal, and in any WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of workyfg life, even if retired) physician ( nen please INDUSTRY COUNTRY? House we 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME e attending permit. The 15 WAS DECEASED EVER IN U.S ARMED FORCES?
(Yes, no, ar unknown) (If yes give war ar dates at service) 16 SOCIAL SECURITY NO 17. INFORMAN Chowy Clease 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSEL AND DEATH signed by the burial-transit p burial, crematia PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) be retained by the haspital ar attending physician. DUE TO Conditions if any, which gove ) ARTERIOSCLEROZIC CARDIOVASCULAR 27EARS rise to immediate cause (a). DUE TO stating the underlying cause as the prior tal has been 2 WELKS ATTENDING PHYSICIAN: The law GANGRENE OF IEFT F-007 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS ALTOPSY PERFORMED? Health for use YES 🔲 ΝĐ certificate 2Do ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter notuse of injury in Port i or Part II of item 18) detached for the Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc TIME OF INJURY Manth, Day, Year 2DH INNERY OCCURRED 2De PLACE OF INJURY (Hame, farm, (City or town) (County) (State) factory, street, affice bldg., etc.) Hour om Nat While DIRECTOR: After or work L at work 21. I certify that (I) (this hospital) attended the deceased fram saw the deceased alive an Italy 19.62 M. from couses and on the date stated above. , and that death accurred at 22a, SIGNATURE 22b DATE SIGNED ATTENDING , page 3 be filed M.D DIRECTOR 22c PHYS CIAN S **ADDRESS** Page 4 may TO FUNERAL NAME (Type) SIMON C, Weiner director, should t 23g. BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY. OCATION (City or Tox (State) una 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 36 25b. VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

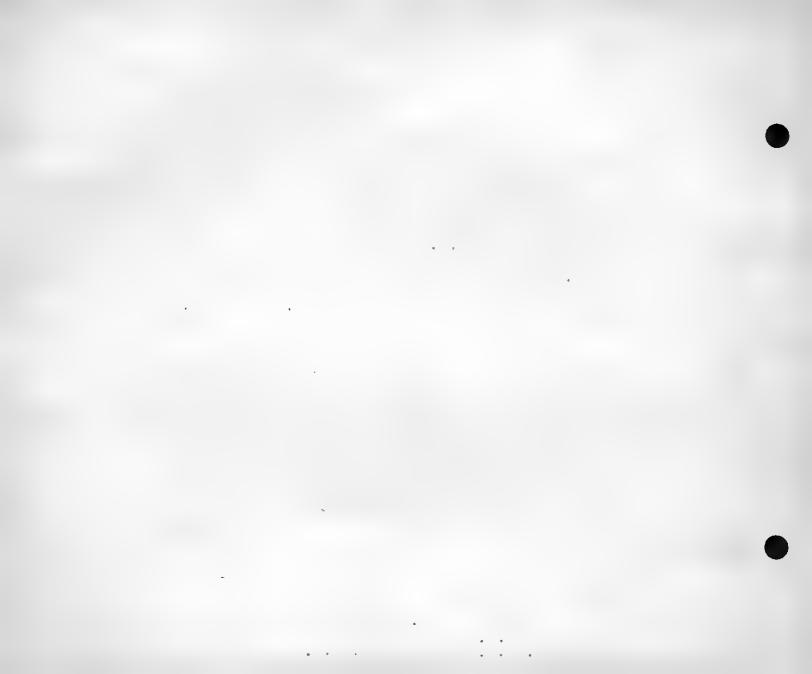
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY o. STATE b. COUNTY MARYLAND b CITY DR TDWN (If guitside corporate limits CLENGTH DE STAY IN 16 c. CITY DR TDWN (If autside corparate firmits, write RURAL and give negrest town) write RURAL and give neorest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARMS NAME OF First Middle 4. DATE Oov Year DECEASED OF SARAH 30 (Type or print) 19 DEATH AGE (In years lost birthdov) S SEX 6 CDLOR OR RACE 7. MARRIED IF UNDER 1 YEAR NEVER MARRIED IF UNDER 24 HRS WIDOWEO OLVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KINO OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Polana MOUSEWIFE

13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar remayal. CHAIM BLOCHARSKY RASHA ---15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address 9320 Grey-(Yes, no, or unknown) (If yes give wor or dates of service Mrs. Jeanette Behrman. rock Rd.S.S.Mc 18. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p IMMEDIATE CAUSE (o) OUE TO Conditions, if any, which gave rise to immediate cause (a). **OUE TO** stoting the underlying couse directar, page 3 shauld be detached far use as the shauld be filed with the State Dept of Health priar to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO certificate 20a. ACCIDENT WAS INDERLYING ... DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF CEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Ooy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, O FUNERAL DIRECTOR: After this (City or town) (County) (Stote) Not While factory, street, office bldg., etc.) ot work 2) I certify that (I) (this hospital) attended the deceased fram 1967,10 1130 19th 1, that (I) (we) last O HOSPITAL OR ATTEND Page 4 may be retained and that death occurred at 1120aM, from causes and on the date stoted abave. 19 5 saw the deceased alive an 22a, SIGNATURE DATE SIGNED **ATTENDING** OIRECTOR. M.D 22c PHYSICIAN'S **ADDRESS** NAME (Type) 230 BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) REMBYALS THE CHEY 7/31/67 Elesvatgrad Cemetery Washington, D.C 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 J3804 09793 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY, ontgomeru MARYLAND b CITY OR TOWN (If outside corporate limits ¿ LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate amits, write RURAL and give namest town) Kensing. signed by the attending physician and completely titled in by burial-transit permit. Then please reprove carban papers. Purial, crematian, ar remaval, and in/any event, within 72 hou d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) S RESIDENCE ON A FARMS d. STREET ADDRESS 4407 Valley YES I NO IV NAME OF DECEASED (Type or print) Lost Oov Year OF DEATH Hewar 25 196 IF UNOER I YEAR S SEX 6 COLOR OR RACE 7. MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 24 HRS NEVER MARRIED lost birthdoy) Months WIOOWED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or logging country) de ring most of working the even if retired). Mechanical engi COUNTRY? INDUSTRY Scranto engineer-U Government 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME William b. Lewis Mary Powell WAS DECEASED EVER IN ILS. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) 75-26-4512 Mary A. Lewis same as #2 NTERVAL BETWEE CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I DEATH WAS CAUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (o) \_ OUE TO Conditions, if any, which gove rise to immediate couse (a), **DUE TO** stoting the underlying couse director, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health prior ta WAS AUTOPS Y PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? YES [ NO O FUNERAL DIRECTOR: After this certificate 20o ACCIDENT WAS UNDERLYING [ 20b OESCRIBE HOW INJURY OCCURRED (Enter noture of unjury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year Hour a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (State) Not While foctory, street, office bldg., etc.) of work 21. I certify that (1) (this haspital) attended the deceased fram 6/1/2/2/2, 19 sow the deceased glive an 7/2/2 19 67, and that death accurred of 4/3/2 to 7/25/2/, 19\_\_, that (1) (we) last M, from causes and an the date stated above 220. SIGNATURE 22b. DATE SIGNED ATTENOING MD DIRECTOR 22c. PHYSICIAN'S 22d. AOORESS NOOD FOLK AVE NAME (Type) IGHM BETHESDA, MD 230 BUR AL, (REMAT ON, REMOVAL (Specify) DUT 181 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) Ft. Lincoln Cemetery Prince Georges County . Mc Hines ADD Smpany 250 REC O BY REGISTRAR 24 FUNERAL DIRECTOR washington, D.C. DATE N.W.



MARYLAND STATE DEPARTMENT OF HEALTH

	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	00895
	09800 CERTIFICATE OF DEATH	0.0000
Ì	b CITY OR TOWN AF a usuale corner determines I a LENGTH OF STAY IN 16 II a CITY OR TOWN Affinitiside corner de limits write PUPAL	MONGOMERY
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS	e IS RESIDENCE On A FARM?
3	DECEASED A DE	Doy Year
S		FUNDER 1 YEAR   IF UNDER 24 HRS.   Min
du	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  100 USUAL OCCUPATION (Give kind of work done lind) USUAL OCCUPATION (Give ki	12 CITIZEN OF WHAT COUNTRY? AMCRICA
19	Is WAS DECEASED EVER IN U.S. ARMED FORCES?  16 SOCIAL SECURITY NO 17 INFORMANT  (Yes no or unknown) (If was also war or dotter of service)	
	18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) CAROLAC AREST	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse (b)  OUE TO  ORUNARY PRTERY DUE  OUT  OUT  OUT  OUT  OUT  OUT  OUT  O	2 days
CERTIFICAT ON	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISFASE CONDITION GIVEN IN PART 1(0)	19. WAS ALTOPSY PERFORMED? YES NO
CAL CERTIF	20b ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town))	(County) (Stote)
MEDICAL	20t TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED of work of	. 195 ) . that (1) (we) las
	saw the deceased alive an 7 - 2 f 196 7, and that death accurred at 145 M, fram causes an 220-STGNATURE  MD ATTENDING DIRECTOR DIRECTOR PHYS	
	221 PHYSICIANS NAME (Type) LIOTIN L. FORD MD 22d ADDRESS 831 UNIVERSIT	MO.
23	230 BURIAL, CREMATION, 236 DATE THEREOF 231 NAME OF CEMPLER OR CREMATORY 23d, LOCATION (City or Town) COLLINGS (City or Town)	

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VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death.

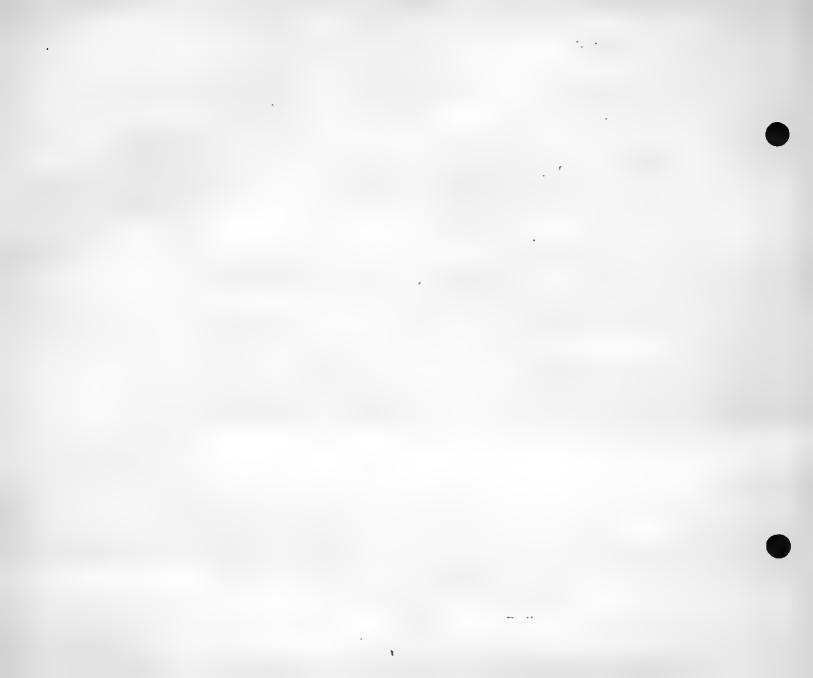
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2000 funeral and 2 and 2 death, after death. PLACE DE DENTH 2. USUAL RESIDENCE (Where deceased lived, It institution; Residence before admission) a. CDUNTY Pages 1 a b. COUNTY Montaomeru Montgomery Taxuland MARYLAND b. CITY DR IDWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 hours Rockville days COCKUILLA papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) filled d. STREFT ADDRESS e. IS RESIDENCE ON A FARM? 4616 Harlan Street ND 3 YES letely completely NAME DE First Middle Lest DATE Year DECEASED event, (Type or print) LOHMETAL DEATH 19 SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IIF UNDER 24 HRS 8. 7. MARRIED北 **NEVER MARRIED** last birthday) | Months any Dec Hours 8, 1888 and emale DIVORCED T WIDOWED [ 10a. USUAL OCCUPATION (Give kind of work done l 10b, KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT ician ease during most of working life, even if retired) INDUSTRY COUNTRY? and U.S.A Housewite Own home death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME remova Then attending | Sarah Little George Owens 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [(If yes give war or dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. 2 587-22-7810 cremation, (Id. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] law requires that the PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) been signed burial, DUE TO buri Conditions, If any, which gava risa to immediate the r to DUE TO cause (a), stating the prior underlying cause last. CERTIFICATION WAS AUTDPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use Health PERFORMED? certificate ND M YES 20a. ACCIDENT WAS UNDERLYING DESCRIPTION OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part il of Item 18.) of o r this cert detached 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, I 20f. (City or town) (County) (State) be de State I factory, street, office bldg., etc.) Hour a.m. After ld be d While Not While at work p.m. at work the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: and that death occurred at Z=22M, from the causes and saw the deceased alive on on the date stated above. 196 SIGNATURE DATE SIGNED 22b. ATTENDING PHYS. MED. PHYSICIAN'S M.D. DIRECTOR PHYS. FUNERAL ADDRESS 22d. director, p should be f MAME (Type) BURIAL, CREMATION, 23b. OF CEMETERY OR CREMATORY LOCATION (City, town or county) DATE THEREOF REMOVAL (Specify) Burial REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a. RECID Marily VR ALS DATE 2DM



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09802 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) deal o. COUNTY b. CITY OR TOWN (If outside conorate limits, write RURAL and give negres) town) The law requires that the death certificate be executed within 24 hours after MARYLAND ontagmerh van papers. Pages within 72 haurs aft c CITY OR TOWN If outside corporate limits, write RURAL and give neglest town) C. LENGTH OF STAY IN 16 in by d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS filled i Washma YES NO TO remove carbon programme and pr 3. NAME OF DATE OF DEATH Last Doy Year DECEASED (Type or print) -OLVA ran 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH ( n years. JE UNDER 1 YEAR lost burthdoy) Months Dovs Hours WIDOWED DIVORCED pup 10o USUA, OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life even if retired) INDUSTRY **COUNTRY?** andi Clout 13. FATHER'S NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN (1) 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO far use as the t Health priar to b stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? irema NO **DIRECTOR:** After this certificate 200. ACC DENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) detached for the Dept of H OR CONTR BUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME DF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE DF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg, etc.) Not While at work L at work 1965 to 21. I certify that (I) (this hospital) attended the deceased from director, page 3 shaufd should be filed with the and that death occurred at 1.27 PM, from couses and on the date stated above sow the deceased alive on 22o. SIGNATURI 22b. DATE SIGNED 22d. ADDRESS TO FUNERAL 23g BURIAL CREMATION 23b DATE THEREO! NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) BANGWAT (SPEELY) Baltimore National Baltimore Marvland VR A15 (4 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09803 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Virginia o. COUNTY **b** COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURA, and give recrest town).

Bethesda (rural) c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) , and in ony event, within 72 hours 42 days Alexandria requires that the death cartificate be executed within 24 haur d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS papers IS RESIDENCE ON A FARM? Naval Hospital 2003 Glen Drive, Belle Haven YES NO 1 and completely fi remove corban 3. NAME OF Middle 4. DATE Last Month Day ¥ea: DECEASED OF DEATH (Type or print) Leland LOVETTE July 10 S. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months WIDOWED Male Cauc. DIVORCED Dec. 11, 1897 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
U. S. Navy INDUSTRY COUNTRY? Greeneville, Tennessee USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME After this certificate has been signed by the attending any be detached for use as the burial-transit permit fren State Dept. of Health prior to burial, cremation, or remayol Oscar Byrd Lovette Lillie Fowler IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address Tennessee (Yes, na, or Linknawn) (If yes give war ar dates of service Capt. Wendell F. Kline, USN, Ret. Sewanee Yes 1917=1949 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

Perforated NTERVAL BETWEEN ONSET AND DEATH Perforated duodenal ulcer with peritonitis IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO stoling the underlying cause **TO FUNERAL DIRECTOR:** After this certificate hos been director, page 3 should be detoched for use as the should be filed with the State Dept. of Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19 WAS AUTOPS PERFORMED? YES K NO ATTENDING PHYSICIAN: 20a ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) Hour Ta.m. factory, street, affice bldg., etc.) at wark al wark 21. I certify that the this hospital) attended the deceased from May 29, 1867, to July 10, 1967, that (1) (we) lost saw the deceased alive 9h July 10, 1967, and that death accurred at 8:00 M, from causes and on the date stated above. Poge 4 may be retoined 22a. SIGNATURE 22b DATE SIGNED STAFF July 12, 1967 M.D DIRECTOR 22c PHYSICIAN 22d ADDRESS W. J. FONTY, M. D. NAME (Type) Naval Hospital, Bethesda, Md. 230 BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Arlington National

VR A15 (4) 25M 1/67



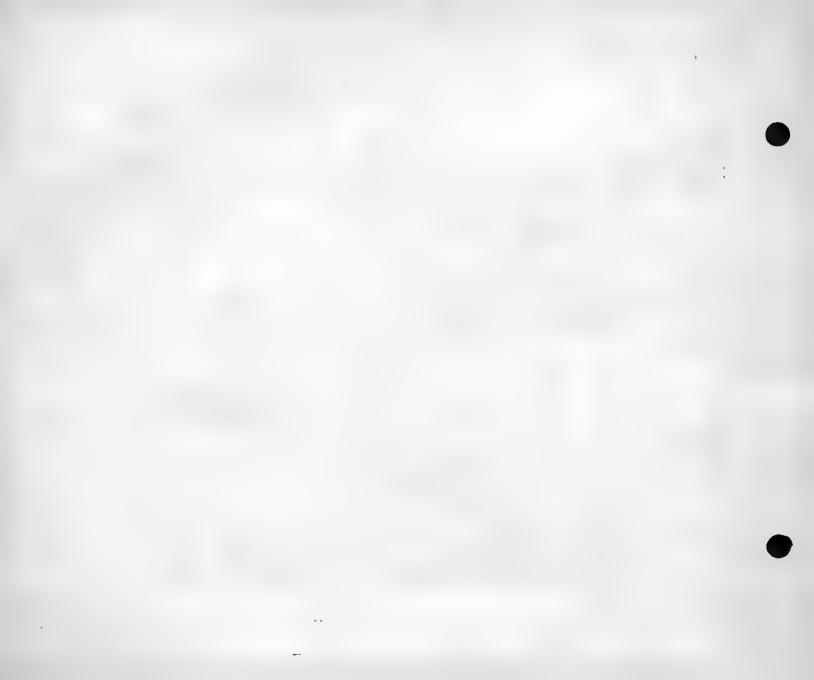
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09804 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN-(If outside corporate firmits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) e IS RESIDENCE ON A FARM? papers. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS NO 17 within carban NAME OF Middle Year DECEASED event, (Type or print) DEATH 196 COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS 7 MARRIED **NEVER MARRIED** femove lost birthdoy) Months Hours WIDOWED DIVORCED and 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY gnd BOMINISTRATIVE ARORIAE 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME maval BERMAN EMA 16. SOCIAL SECURITY NO 17 INFORMANT ELENUIEW, AVE (Yes, no, or unknown) (if yes give war or dates of service) -12.5358 MORRIS 7*ES* IB. CAUSE OF DEATH (Enter on y one couse per line for (o) (b), and (c))
PART I DEATH WAS CAUSED BY NTERVAL BETWEEN signed by the burial-transit burial, cremat ONSET AND DEATH harach IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO ra cromal Conditions, if any, which gave nse to immediate couse (o), DUE TO stating the underlying couse the Health prior to SS WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO of 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 16 of item 18) 200 ACCIDENT WAS UNDERLYING [ detached f te Dept. af l OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg, etc.) Not While of work **DIRECTOR:** After 2) I certify that (I) (this haspital) attended the deceased from 2-20 19 director, page 3 should should be filed with the saw the deceased alive an. and that death accurred of from couses and on the date stated above. 220 SIGNATURE DATE 5 GNED DIRECTOR M.D PHYS CIAN S 22d ADDRESS O FUNERAL NAME (Type) 236 BURIA CREMATION 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (Cittle or Town) (County) (Stote) REMOVAL (Speculy) 24 FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 256 REG STRAR S SIGNATUR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

098111

99805 corbon papers. Pages 1 and 2 and 2 and 2 and 3 a PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND ONTGOMERY 24 haurs after Pages b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town write RURAL and give nearest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? Ξ. d. STREET ADDRESS filled NO D YES requires that the death certificate be executed within NAME OF Middle DATE Lost Doy Year completely DECEASED OF DEATH (Type or print) SEX lease remave, and in any eve 9. AGE (In years IF UNDER 1 YEAR 7 MARRIED **NEVER MARRIED** DATE OF BIRKS Months Doys Hours WIDOWED DIVORCED and 10o USUAL OCCUPATION (Give kmd of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician ien please during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, ig phy Then WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address permit. (Yes, no, or unknown) (If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the c burial-transit p IMMEDIATE CAUSE (a) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO s certificate has been s sched far use as the b spt. af Health priar ta b stoting the underlying couse last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO 🔀 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH State Dept. of detached (IF EITHER, NOTIFY MEDICAL EXAMINER! MEDICAL 20e PLACE OF INJURY (Home, form, (Stote) TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20f. (City or town) (County) HOUT OUT While Not While foctory, street, office bldg etc.) of work of work ě 21. I certify that (1) (this hospital) attended the deceased from director, page 3 should should should be filed with the TO FUNERAL DIRECTOR: saw the deceased alive and its 100 , and that death occurred at from cause's and on the date stated above 220. SIGNATURE 22b DATE SIGNED ATTENDING M D DIRECTOR PHYS 23c NAME OF CEMETERY OR/CREMATOR DESCRIPTION (CHY DESTO (Stote) BUR AL CREMATION REMOVAL (Specify) 256 REGISTRARS SIGNATURE 250. RECD BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 99806 09811 CERTIFICATE OF DEATH  $\sim$ rsician and completely filled in by the funeral please remove carbon aggers. Pages 1 and 2 l, and in ony event writh in 72 hours after death. requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased ved, if institution Residence before admission) o. COUNTY o. STATE **b.** COUNTY Montgomery

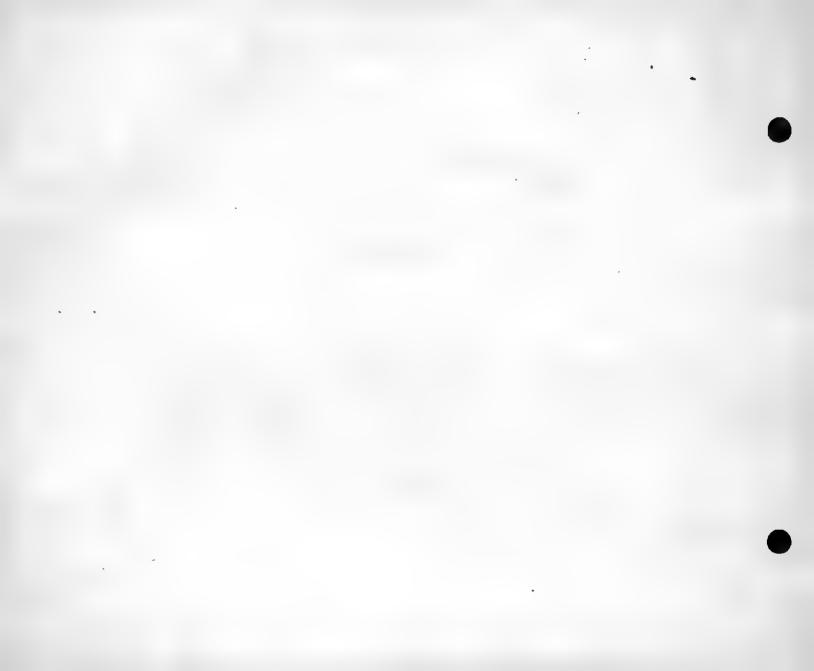
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Virginia € LENGTH OF STAY IN 1b. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Days Bethesda Vienna d NAME OF HOSP TAL OR INSTITUTION (If not in haspita, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? 2441 Shennandoah St. NO F Naval Hospita Middle 4. DATE Lost Dov DECEASED (Type or print) Mahaffey DEATH Daniel Alonzo July S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years IF JNDER 24 HRS 7 MARRIED lost birthdoy) Months Days WIDOWED DIVORCED Cauc 17 March 1926 47 yrs 100 USUAL OCCUPATION (G ve kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHP, ACE (County & State or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** KINGS MOUNTAIN, N.C. U. S. 13 FATHER'S NAME signed by the ottending physi burial-tronsit permit. Then pl burial, cremotion, or removol, Lucille Gilliam Sidney C. Mahaffey
WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address 2441 Shennandoah Street (Yes, no, or unknown) (If yes give war or dates of service) 247 32 6538 Joyce Mahaffey WW II- Korean Vienna, Virginia 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Hodgkins Disease O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or ottending physician. DUE TO Conditions, if any, which gove rise to immediate cause (o), DUE TO stating the underlying couse oge 3 should be detached for use as the fled with the State Dept. of Health prior to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES K NO 200 ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) TO FUNERAL DIRECTOR: After this Not While Hour o.m. factory, street, office bldg, etc.) 21. I certify that (I) (this haspital) attended the deceased fram 12 June , 1967, to 30 July , 1967, that (K (we) last saw the deceased alive of 30 July 1967, and that death accurred allowed M, fram causes and an the date stated above 220 SIGNATURE 22b DATE SIGNED STAFF 31 July, 1967 DIRECTOR director, page should be filed 22d ADDRESS 22c PHYSICIAN S NAME (Type) Naval Hospital, Bethesda, Maryland 23d LOCATION (City or Town) 23o. BURIAL, CREMOTION, REMOVAL (Specify) DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (Stote) Arlington National Cemetery Arlington, Virginia
ADDRESS 250 RECO BY REGISTRAR 256 REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS Vienna Money and King, Maple Avenue. VR A15 (4) 25M 1/67 Victories Jugar Virginia



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09807 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. puo 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH the funera b. COUNTY after 98 mor lant MARY! AND SUSSFY 5 CTY OR TOWN OF autside corporate I mits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest fown) hours 60 filled in 1 NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENC ON A FARM NO. YES DATE OF DEATH NAME OF Myddle Month Doy Year remave carban DECEASED (Type or print) and in any event IF JINDER 6 COLOR OR RACE 9. AGE (In years MARRIED NEVER MARRIED pirthdoy) lost Months Dovs Hours WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) ease COUNTRY *INDUSTRY* 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, 17 INFORMAN HAWKES PURILLEN (Yes, no, or unknown) (If yes give wor or dates of service) CAUSE OF DEATH (Enter only one couse per line PART ! DEATH WAS CAUSED BY signed by the burial-transit p IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse director, page 3 should be detached far use as the should be tiled with the State Dept. af Health priar to WAS AUTOPSY PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAND TO THE TERMINA. DISEASE COND T ON GIVEN 200 ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW IN JRY OCCURRED (Enter noture of injury in Port I or Parties as a line of the land of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg , etc.) Not While of work 21 I certify that ## (this haspital) attended the deceased from and that death accurred at Too Riffiam causes and on the date stated above saw the deceased alive on DATE SIGNED 220. SIGNATURE M.D DIRECTOR PHYS 22d O FUNERAL NAME (Type) DO N 230 BUR AL, CREMATION, DATE THEREOF (Stote) REMOVAL (Specify) JOHNSTOWN Cemeter GREENHOOM 2Sb. REGISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR VR A15 (4) DATE AUG 25M 1/67

1,

	MARYLAND STATE DEPARTMENT OF HEALTH	
in l	39808 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	2042
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	3813
, HEALTH DEPT.	1 , PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence	before admission)
Bridge	o COUNTY Man team ence MARYLAND STATE May Le L. COUNTY MA	to the man
5 m & 1 & 1	b CITY OR TOWN (1 outside corporate limits   c LENGTH OF STAY IN 1b   c C TY OR TOWN at a scribe corporate limits, write RuRA1 and give	perfest town)
A del del	write BIRAL and give rearest town Years. Kockwille	
2, and PM3- E	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street address)  d. STREET ADDRESS  d. STREET ADDRESS	e IS RESIDENCE ON A FARM?
arm arm	24 E. Ment yone y A Ve. CHAT2 24 E Montgomeny aux	YES NO
24 hours after death. It in Item 18. Give Pages it's Office along with far es lamd 2 with the State offer death.	3 NAME OF Frst Middle Lost   4 DATE Month	Day Year
9 8 8 8 9 9	(Type or print) Ruly H. MANTER DEATH Seely 25	1 , 1967
ifter Gring	S SEX 6 COLOR OR PACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 NOT (In years IFUNDER 1 lost birthday) Months	VEAR IF UNDER 24 HRS Doys Hours Min
18. af 18. e ak 2 w'	WIDOWED DIVORCED 766 1701. 66 VIS	
thours litem 1 Office land2 er death	during most of working life even if retired) INDISTRY	ZEN OF WHAT
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within 24 pencil in cominer s ile pages haurs afte		
with per Exorr	Walter H. Manter Cora Elledge	
ted "in all E	15. WAS DECEASED EVER IN L.S. ARMED FORCES? (Yes, up. or unknown) (If yes give wor or doles of service)  16. SOCIAL SECURITY NO. 17. INFORMANT  6010 dd Vak St No.  17. INFORMANT  18. SOCIAL SECURITY NO.  18. SOCIAL SECURITY NO.  19. INFORMANT  19. INFORMANT  10. INFORMANT  10. INFORMANT  10. INFORMANT  11. INFORMANT  12. INFORMANT  13. INFORMANT  14. SOCIAL SECURITY NO.  15. INFORMANT  16. SOCIAL SECURITY NO.  16. SOCIAL SECURITY NO.  17. INFORMANT  18. SOCIAL SECURITY NO.  18. SOCIAL SECURITY NO.  19. INFORMANT  19. INFORMANT  10. INFORMANT  11. INFORMANT  12. INFORMANT  13. INFORMANT  14. INFORMANT  15. INFORMANT  16. SOCIAL SECURITY NO.  17. INFORMANT  18. INFORMANT  19. INFORMANT  19	reet
xecuted nding"   Medical permit		Mo- INTERVAL BETWEEN
	18 CAUSE OF DEATH (Enter on y one couse per line for (o). (b) ond (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE (A. SE (a) Coute cardiac dilatation	ONSET AND DEATH
shauld be en ward "per a the Chief." burnal-tramsit any event		<del>suddex</del> —
war war he	Conditions, if ony, which gove ) DUE TO  Conditions, if ony, which gove ) (b) Secondary anemia	2 years
s shaul the wa ta the burral- in any	rise talimmed ofe couse (o), DUE TO	2 years
This certificate shauld cate, wr ting the ward be forwarded to the Clowarded to the Clowards on a burial-transmayal, and in any every	stoting the underlying couse (i) Myelofibrosis of bone marrow	r years
certif , wr tii orward used c	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED?
orte, v e for bir us	ATION	YES X NO
EXAMINER: This certition to the the certificate, wrigge 4 shauld be forwayour files Page 3 shauld b⊯ used cremation, or remaval,	200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH  201 I.ME OF INJURY Month, Day, Year Hour o.m.  202 I.ME OF INJURY Month, Day, Year While Not While factory, street, office bidg., etc.)  203 EXTERNAL CAUSE WAS PRIMARY Or COURRED (Enter nature al injury in Part I or Port II of item 18.)  204 I.ME OF INJURY Month, Day, Year While Not While factory, street, office bidg., etc.)	
NER: T certifica hauld b iles shauld an, or n	CAUSE OF DEATH	
EXAMINER: ute the cert age 4 shauld your files Page 3 shau crematian, a	20c I.ME OF INJURY Month, Day, Yeor 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form About o m. While Not While foctory, street, office bldg., etc.)	nty) (State)
Medical EXAM please execute the director Page 4 estained for your DIMECTOR: Page in to bur al, cremain	p.m. 19 of work 🗀 of work	
L EXA cecute Page far yau R:Pagy	21. I certify that I took charge of the remains described above, held an Autopsy 💢 , Inspect on 💢 , Inquiry 💢 ,	ond in my apinian
JTY MEDICAL  Ty, please exected director P.  Be retained far  RAL DIRECTOR.  prior to bur al,	death resulted fram Natural causes 🔀 , Accident 🗌 , Suicide 🗍 , Homic de 🔲 , Undetermined manner 📗	
Medical please et al director retained bur to bur to bur	ACTUAL CHIEF MEDICAL EXAMINER CHIEF MEDICAL CHIEF MEDICAL CHIEF MEDICAL CHIEF MEDICAL CHIEF MEDICAL CHIEF MEDICAL	22. DATE SIGNED
7 P P P P P P P P P P P P P P P P P P P	DEBITY MEDICAL EVANIMED R	7
DEPUTY stessary, e funeral may be r may be r	EXAMINER'S NAME (Type) John G. Ball Address (Street, city town, or county)	
necessary, please exite funeral director 5 may be retained to IMNIEML DIRECTOR Health prior to burn	230 BURIA CREMATON 236 DATE THEREOF 237 NAME OF LEMETERY OR CREMATORY 23d LOCATION (City of Town)	County) (State)
01 5 ± ₹ 2 0 ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ±	Bur-Transit 3/1/67 Oak Hill Cemetery Laurence, Missou	ri
VR A15ME (5)	26 RELINEARS SU	By Judge
6M 1/67	Tyson Wheeler Funeral Home-1331 Rockville PikeAUG 2 1967 follows	0 0
	- TOCKVIIIe - ARYIANG	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09803 CERTIFICATE OF DEATH death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death a. COUNTY o. STATE b. COUNTY MARYLAND C LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate names c. CITY OR TOWN auxide cornorate limits, write RURAL and give augrest town d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled YES l no [ NAME OF Middle DATE Lost Day Year DECEASED OF 1967 (Type or print) DEATH 1F UNDER 1 YEAR IF LINDER 24 HRS S. SEX 9. AGE 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** DATE OF BIRTH (In year birthdoy Months in arry WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME removol. WAS DECEASED EVER IN U.S. ARMED FORCES? **36 SOCIAL SECURITY NO** (Yes, no, or unknown) [(If yes give war or dates of service) 6 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) LYMPHOBATCOMA INTERVAL BETWEEN buriol-transit ONSET AND DEATH DUE TO signed Conditions, if any, which gove (b) rise to immediate cause (a), DUE TO stating the underlying couse hos been lost. 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES X NO certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port t or Port I, of item 38) 200 ACCIDENT WAS UNDERLYING I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF .NJURY (Home, form, (City or fown) (County) (Stote) Hour am While Not While factory, street, office bidg., etc.) of work ot work 21. I certify that (1) (this haspital) attended the deceased fram 19 ., 19\_\_\_, that (1) (we) last , ta 4 may be retained , and that death accurred at M, fram causes and an the date stated above saw the deceased alive an. FUNERAL DIRECTOR: 22b DATE SIGNED 220 SIGNATURE DIRECTOR director, pog-22d ADDRESS 22c. PHYSIC AN'S O HOSPITAL NAME (Type) 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) BUR I AL GROVE CEMETERY LAYTONSVILLE 250. RECPIBY REGISTRANG FUNERAL DIRECTOR

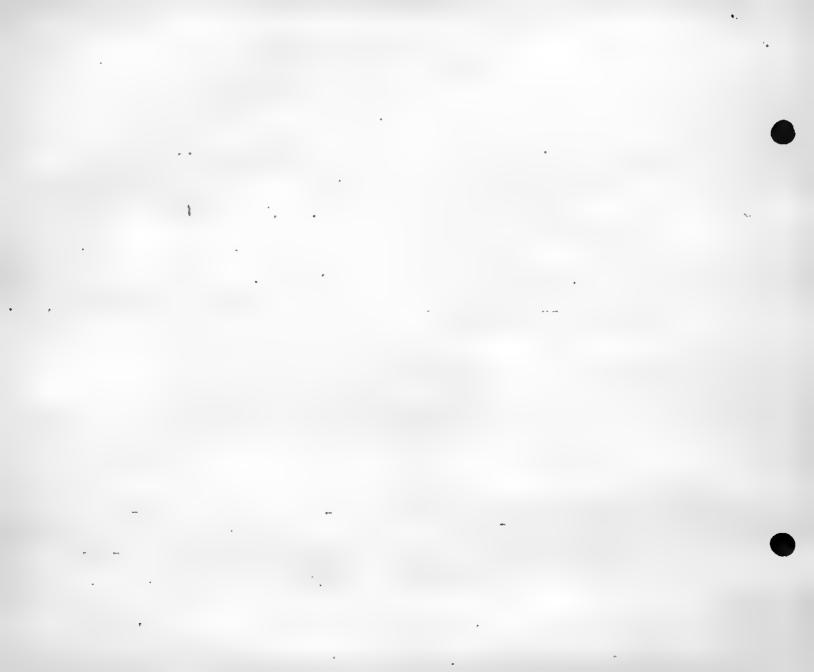


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00810 09815 CERTIFICATE OF DEATH The low requires that the deoth certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) n COUNTY o. STATE **B COUNTY** Montgomery MARYLAND Maryland b CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Gaithersburg Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS E IS RESIDENCE ON A FARM? Asbury Methodist Home for the Aged, Inc. 4506 Avondale St. NO X YES 3. NAME OF Middle First Last 4. DATE Month Year corba DECEASED July 27 1967 Martha Mathieson (Type or print) Freme DEATH 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last pirthday) Months Haurs Min. April 6, 1884 W and in ony WIDOWED X DIVORCED pup 10g USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
housewife INDUSTRY COUNTRY? Glasgow, Scotland 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME buriol, cremation, or removal. Alexander Freme Annie Brown 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, na, ar unknown) (If yes give war ar dates of service) Asbury Methodist Home, Gaithersburg, Md. 579-03-3882D 18 CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c).)
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying cause 3 should be detached for use as the with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? zus sus NO After this certificate is be detached for us 20a ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Not While factory, street, office bldg . etc.) at wark 21 I certify that (1) (this hospital) attended the deceased from 5/16/6 6719\_\_\_, that (1) (we) last and that death occurred at 250AM, from causes and on the date stoted above. DIRECTOR: 126/6719 saw the deceased alive an\_ 22a SIGNATURE 226 DATE SIGNED director, page 3 shauld be filed v DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL &&11) 7720 Wisconsin Ave., Bethesda NAME (Type) HENRY SCRUGGS, M.D. 23d LOCATION (City or Town) 230 BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Washington, ROCK GREEK CEMETERY D.C. REC D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 69816 09811 CERTIFICATE OF DEATH von papers. Pages 1-and within 72 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, it institution. Residence before admission) MONI GOMERY g. STATE 5. COUNTY MARYLAND MARYLAND MONTGOMERY filled in by the Tu b (ITY OR TOWN (foutside corporate limits, write RURA, and give nearest town)

Bethesda c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 The low requires that the death certificate be executed within 24 hours vrs. BETHESDA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS 6048 Avon Dr. 6048 Avon NO S YES 🗔 o complet∎ly fi 3 NAME OF Fiest Middle Last DATE Doy Year DECEASED OF **JOHN** J. McDONALD TIIT. 19 67 (Type or pnmt) DEATH S SEX AGE (In years IF LINDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE B. DATE OF BIRTH 7 MARRIED **NEVER MARRIED** birthdoy) Hours Days WIDOWED DIVORCED □ Aug. 26,1915 MALE 26 the ottending physician one sit permit. Then please rea 12 CIT ZEN OF WHAT 10o USUAL OCCUPAT ON (Give kind of work done 105 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY **COUNTRY?** Carpenter
13. FATHER'S NAME Billings. Montana Building 14. MOTHER'S MAIDEN NAME AGNES G. GILSKEY JOSEPH W. McDONALD -8126401d GeorgetownRe 16. SOCIAL SECURITY NO 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) (Bethesda, Md. DONALD S. McDONALD 578-30-5149 No TB CAUSE OF DEATH (Enter only one couse per line for (b), and (c).)
PART | DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH O FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the buriot-fronsit IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (o) DUE TO stating the underlying cause as the prior to b lost PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? for use ( Health p NO X YES F 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [ detoched for the Dept. of P OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detoche should be filed with the State Dept. 20c TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While factory, street, office bldg., etc.) of work ot work 21. I certify that (1) (this haspital) attended the deceased from 5-9-. 19 67, to\_\_\_\_ 7-22- 19 67 that (I) (we) last 1967, and that death accurred at 1:43M, fram causes and on the date stated above saw the beceased alive an 7-22-22b DATE SIGNED 7-23-67 220. SIGNATURE DIRECTOR 22d. ADDRESS 10401 22c. BHYSICIAN'S "Old Georgetown Rd., Bethesda RONALD BARR NAME (Type) 23d. LOCATION (City or Town) (County) 23c NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23o. BURIAL, CREMAT ON, REMOVAL (Specify) Rockville, Maryland
REGISTRAR | 25b. REGISTRAR S SIGNATURE Parkhawn Cemetery July 25,1967 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 JUL 25 1967 VCharles Judy BETHESDA MD. ROBERT



of please remave carbon papers. Pages 1 and oval, and in any event, within 72 haurs after death hysician and campletely filled in by the fur A niense remaye carbon papers. Pages 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

10 FUNERAL DIRECTOR: After this certificate has been signed by the attended director, page 3 shauld be detached for use as the burial-transit permits shauld be filed with the State Dept. of Health prior to burial, cremation, or

VR A15 (4) 1 25M 1/67

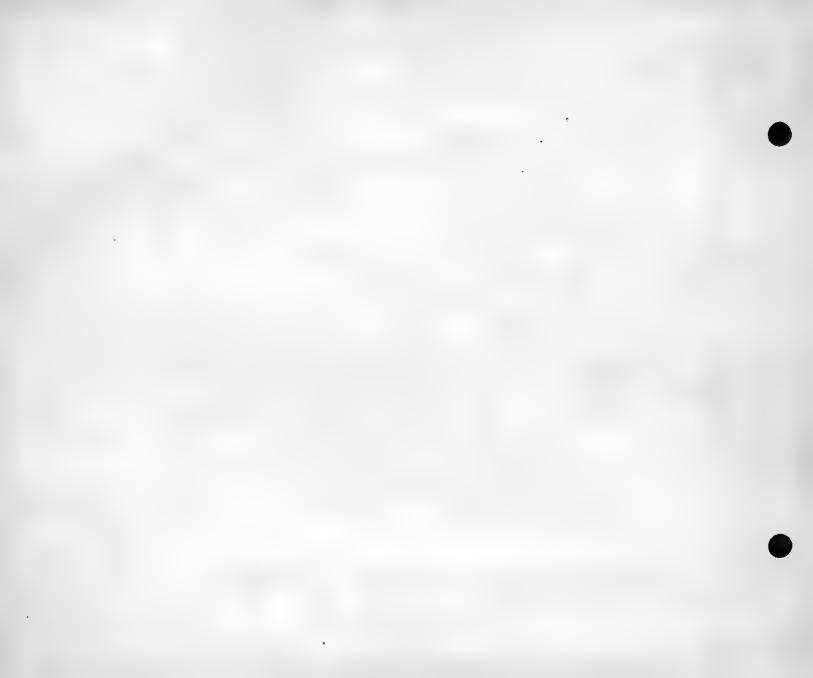
Page 4 may be retained by the hospital ar attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1.00 1 m

					00011					
PLACE OF DEATH			2. USUAL RESIDE	NCE (Where deceased lived, if ins	titut on Residence before admission)					
o. COUNTY	Cantramani	\$\$ 4 Politi & 6.1	D. STATE M	<b>d</b> b. (	COUNTY Pro Geo					
	Iontgomery (If outside corporate limits,	MARYLAN	U							
write RURAL or	of give neorest town)	E LENGTH OF STAT IN II		(If outside corporate emits, write lege Park, Md.	KUKAL and give nearest town)					
Tokoma ta	nd give neorest town)		COI	rege rark, Mu.	16 .					
d NAME OF HOSP	TAL OR INSTITUTION (If not in h	respital, give street address)	d STREET ADDRE		B IS RESIDENCE					
ash Sanit	tarium and Hos	pital	5901	Natasha Drive	ON A FARM?					
3 NAME OF	First	Middle	Lost	4 DATE						
DECEASED (Type or print)	Jessie	N	McKey		July 12, 19 67					
S. SEX	6. COLOR OR RACE 7 A	MARRIED NEVER MARRIED	B. DATE OF BIRTH	9 AGE (In year	F UNDER 1 YEAR IF UNDER 24 HRS.					
male		IDOWED TO DIVORCED		L892 74 birthday	rs					
100 LSUAL OCCUPATIO	N (Give kind of work done	10b. KIND OF BUSINESS OR	,	County & State, or foreign country)	12 CITIZEN OF WHAT					
during most of working	gure, even u repredj 1 <b>er</b>	NDUSTRY Parming	North (	Carolina	U S A					
13. FATHER'S NAME			14. MOTHER'S MA	AIDEN NAME						
	Luke W McKoy		Annie	L Taylor						
IC WAS DESCRISED OF	ED IN HE ADMED EODOES	16. SOCIAL SECURITY NO.	17. INFORMANT		ıddress					
(Yes, no, or unknown)	(If yes give wor or dotes of serv		Linwood W A							
no		210 20 0101	Diriwood " P	ckoy Beltsvil	le, Md.					
	EATH (Enter only one couse pe	r line, far (o), (b), and (c).)	1		INTERVAL BETWEEN					
PART 1 DEA	ATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Liver F	-ailure	2_	ONSET AND DEATH					
	DUE TO		- 4	,						
Conditions, if an	which many	Pinhas : o	· Chal	angitis						
rise to immedio	te couse (o),	C/F F/ 502/ =	, Cruci							
stoting the unde	eriying couse	Tutudantic	Biliary .	CHRIC						
last	) (i)									
PART II. OTHER S	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19 WAS ALTOPSY PERFORMED?									
Gast	ric il/cers	s, bemoragic			YES NO					
200 ACCIDENT WAS JINDERLYING   20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18)										
OR CONTRIBUTING	G CAUSE OF DEATH		'	,	,					
THE EHREN, WOHE	Y MEDICAL EXAMINER)	20d INJURY OCCURRED 200	DIACT OF INITIDY /Nom	o form 206 ICsb. or tour	i) (County) (State)					
20c. TIME OF IN.	IURY Month, Doy, Yeor	While Not While	<ul> <li>PLACE OF INJURY (Hom foctory, street, office bld</li> </ul>		n) (County) (State)					
E p	p.m. 19 of work of work of work									
21. I cert	21. I certify that (1) (this haspital) attended the deceased from 4/30 , 1962, to 7/12/ , 1967 that (1) (we) last									
saw the c	saw the deceased alive an $\frac{1}{2}$ 1967, and that death accurred at M, from causes and an the date stated above.									
220 SIGNATURE	226. DATE SIGNATURE									
(horas	ATTENDING TO MED STAFF TO THE TOTAL TO THE TOTAL									
27 PHYSICIAN	A - 1 CC - A COUNTY A									
	NAME (Type) Joseph E. Smith, J. M.D. Bustonsulle, Mil									
	V 0 3C / C /	* * * * * * * * * * * * * * * * * * * *								
230 BURIAL, CREMATI	ION, 23b DATE THERFOR	23c NAME OF CEMETER		23d LOCATION (City o						
REMOVAL (Specifical)	" July 15,	1967 Ft Lincoln	Cemetery	Colmar Mand						
24 FUNERAL DIRECT		ADDRESS	250	REC'D BY REGISTRAR 255	REGISTRAR'S SEMAJURE					
	r dasch s of	ms nyattsville	p PICL.	1001 1 1 111.						



	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	19913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10918
HEALTH DEPA	1. PLACE OF DEATH  2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before edmission
<b>を発 * 制      </b>	e. COUNTY  b. COUNTY
SS 2. SS 2	Montgomery  Maryland  Maryland  Montgomery  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (if outside corporate limits, write RURAL and give neerest lown)
of 1	Write KUKAL and give neerest town)
D S S S S S S S S S S S S S S S S S S S	Takoma Park 15 min. Silver Spring Wheaton
1 5 S	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street eddress)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
	Washington Sanitarium & Hospital 11722 Grandview Avenue
State	3. NAME OF First Middle Last Adu DATE Month Dey Year
5455 / Y	(ype or print) ROAA Paulor Statestos DEATH 7 30 1967
4.52.4	S. SEX   6 COLOR OR RACE 7. MARRIED NEVER MARRIED   8. DATE OF B.RTH   9. AGE (In yours   IF UNDER 1 YEAR "IF UNDER 24 HRS.
de de de s	lest Dirinday)   Months   Days   Hours   Man
16.7.01 15.01	Male Cauc. WIDOWED DIVORCED ST STATES 100. USUA. OCCUPATION (G ve kind of work 10b. KIND OF BUSINESS OR INDUSTRY) 11. BIRTHPLACE (Slete or foreign country) 12. CITIZEN OF WHAT COUNTRY
Sal 2	done during most of working life, even if relitad)
Page 2. ri	None None Maryland U.S.A.
4 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	13. FATHER'S NAME
1 1 2 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Frank Medeiros Joan Luckett
4 - 2 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unknown); (((yesgivewerordates of service))
Walter W	AL A
e i i i i i i i i i i i i i i i i i i i	18. CAUSE OF DEATH [Enter only one couse per line for (e), (b), and (c).]
ni l programa program pro	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Respiratory failure  ONSET AND DEATH 40 min.
aria di la	
Id to be propertied to be	DUE TO
o	Conditions, if any, which (b) Dislocation of neck between C1 and C2 40 min.
ling er's er's	(a) statung the underlying > DUETO
Min min ed	cause lest. (c) Fall and hitting chin 40 min.
Francia of	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  VES PRIMARY TO OF CONTRIBUTING   20a EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING   20b DESCRIBE HOW INJURY OCCURED. (Enler neture of injury in Part I or Part II of I tem 18.)
d b	None YES No X
out out	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
E State	RELIGIOUS PROPERTY OF THE PROP
High Section 1	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
Page 4	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  Hour e.m. 7/30/6% et work et work Home Silver Spring, Mont., Md.
XX 왕년 영년	21. I certify that I look charge of the remains described above, held an Autopsy . Inspection X. Inquiry . and in my opinion
E SE	death resulted from. Natural causes , Accident X. Suicide . Homicide . Undetermined manner
0 4 4 K B	CHIEF MEDICAL EXAMINER
E P	
for for safe	SIGNATURE
P P P P P P P P P P P P P P P P P P P	EXAMINER John S. Rogers, M.D. DEPUTY MEDICAL EXAMINER X 7/30/67
DEPUTY 19 asse execute should be for FUNERAL its designal	NAME (Type) 1919 Seminary Rd., Sil. Srp., Md. Address (Street, city, Jown, or county)  226. BURIAL, CREMATION, 226. DATE THEREOF  226. NAME OF CEMETERY OR CREMATORY  1 22d. LOCATION (City, Jown, or country)  (Stete)
(1)	REMOVAL (Specify)
5 4 5 9	Burial August 2, 1967 Fort Lincoln Cenetery Prince Georges Co. Maryland
VS. A15ME	23. OVERAL DIRECTOR Carles 813: Georgia Avenue 24. REC'D BY REGISTRAR'S SIGNATURE ALLC 1 1967 Williams Verlage
5M 7/59	Warner E. Pumphney, Inc. Silver Spring, Md. DATE AUG 1 1967 yourses Judges
( ) (	

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **100** MEDICAL EXAMINER'S CERTIFICA PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence perfore admission) o COUNTA MARYLAND b CITY OR JOWN (If outside conforate I mits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 carparate limits, write RURAL and a very orest tawn gud offer d STREET alang with farm Give Pages NAME OF DATE DECEASED OF E ONA DEATH COLOR OR RACE NEVER MARRIED AGE (In years, 3 birthday) Months WIDOWED Office gug 106 K ND OF BUSINESS OR In any pages gup 윤 INFORMANT 039 permit. remayal, CAUSE OF DEATH (Enter only one cause per light for (a), (b), and (c) **burial-transit** PART I DEATH WAS CAUSED BY. ö IMMEDIATE CAUSE (o) This certificate should ward crematian, DUE TO Conditions, if any, which gave nse to immediate cause (a). DUE TO storing the underlying couse D last. used as CONTRIBUTING TO DPATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) its designated agent, prior to 20a EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING [] 3 should CAUSE OF DEATH CA 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form, (City or town factory street, office bldg , etc.) Not While FUNERAL DIRECTOR: Page Diedse execute 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection the funeral directar. death resulted fram Natural causes Suicide Accident Hamicide Undefermined manner be retained CHIEF MEDICAL EXAMINER **ACTUAL** ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** TO FUNE! Addres 7 (Street Cuty, down pr county) may BURIAL CREMATION. DATE THEREOF David Memorial Garden 7/21/67 Stein

23d LOCATION (City of Town) Falls Church, RECD BY REGISTRAR 25b REGISTRAR'S SIGNATUR VR A15ME (5) Memorial Funeral Home 6M 1/66

ON A FARMS

Haurs

INTERVAL BÉTWEEN

ONSET AND DEATH

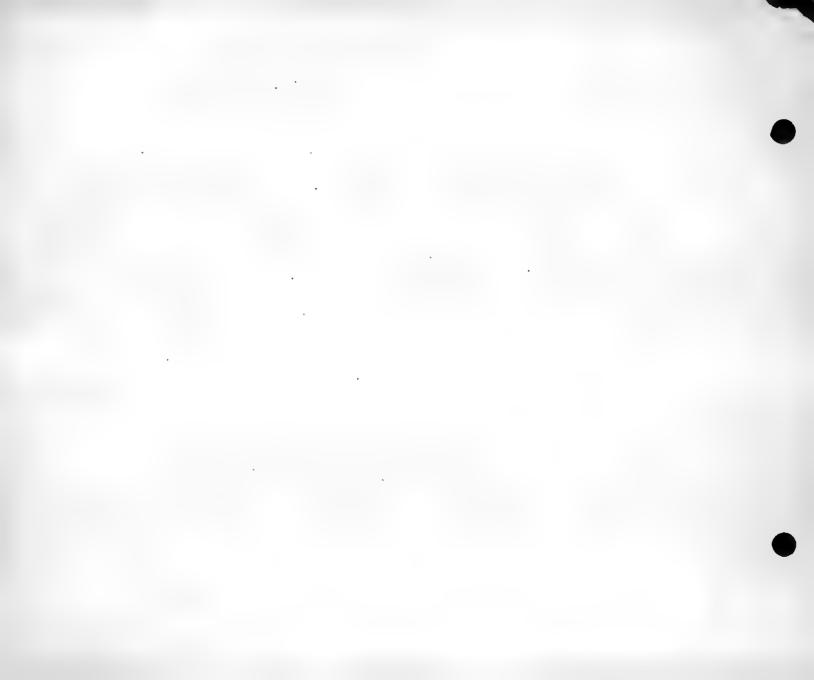
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22. DATE SIGNED

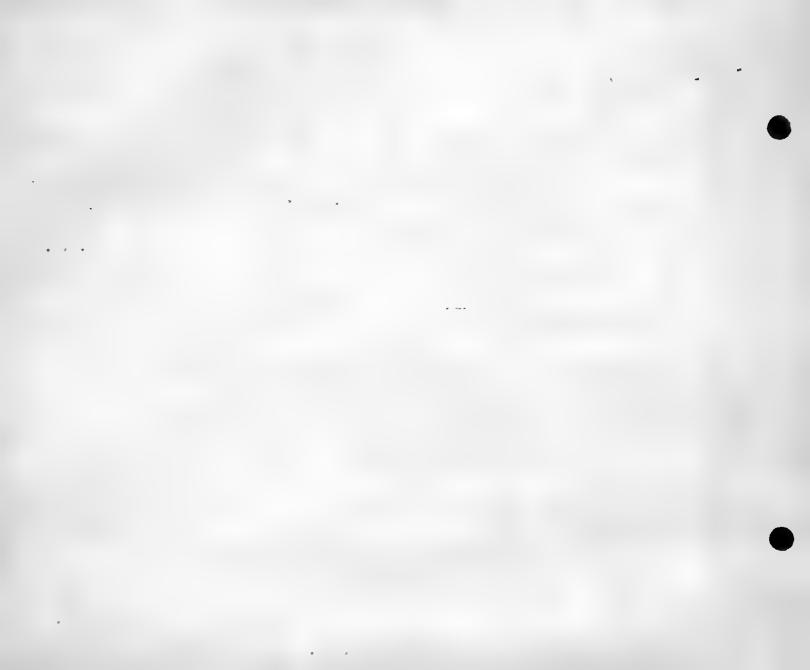
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12. CITIZEN OF WHAT



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i by the funeral Pages Land		PLACE OF DEATH COUNTY Montgom	ery		MA	RYLAND	2 USUAL RESIDENCE (V o. STATE Virgi		ived, if instituti b COUN		fore admission
ages after		LITY OF TOWN (	tf outside corparate lind give neorest town)	uts,	c LENGTH OF STAY	lk lb	c. CITY OR TOWN (If ou	tside corporate i	mits, write RUR	At ond give neo	rest town)
4 hau		NAME OF HOSPIT	AL OR INSTITUTION (IF				d STREET ADDRESS	rge			e IS RESIDENCE ON A FARM?
in See 2			spital, Be				Box 77				YES X NO
the Later		NAME OF DECEASED (Type or print)	<b>J</b> ohn	First	Middle Albert		lost MEROTH	4. DATE OF DEATH	Jul:	v 2	loy Year 1967
executed within 24 haurs at a completely filled in by the mave carban papers. Page ny event within 22 hours any	5		6 COLOR OR RACE	7 MARRIED WIDOWEL	NEVER MARRI		6 Jul 1911	1 0 a	GE (In years  ist birthdoy)  ves	IF UNDER 1 YEA Months Doy	R IF UNDER 24 HRS.
i be ex in and se rem	Inn	LISUA, OCCUPATION	N (Give kind of work don life, even if retired) Y (retired	ne 10b	KIND OF BUSINESS OR INDUSTRY		New Haver		n country)	12 CITIZEN UCOUNTR	OF WHAT
cate Sicio plea , an	13	FATHER'S NAME	1 (recired				14. MOTHER'S MAIDEN I				
phy en ova	A	lbert ME	ROTH				Helen HANS	MAN			
in a ce	15	WAS DECEASED EVI	RINUS ARMED FORCE	S? 16	SOCIAL SECURITY NO	17. 1	NEORMANT		Addre BOX	\$\$ <sub>77</sub> 7	
dea tend trmit	(76	yes	10-2-42to1	-30-63	045 03 886	00 Mrs	s. Simone M.	MEROTE	I Kin	r Ceorge	- Vo
D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.  D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carban pages. Pages L and 2 shauld be filed with the State Dept. af Health priar to burial, cremation, or removal, and in any event, within 2 hours after death.		18. CAUSE OF D PART I. DEA 16 27 Conditions, if ony rise to immediat stoting the under lost.	, which gove te couse (o), {	(b)	or (o), (b), and (c).)	right	lung with M	letastas	is		INTERVAL BETWEEN ONSET AND DEATH
The lor aften to the has to use as the harith pride the harithment that harithment the harithment that harithment that harithment the harithment that harithment t	VIION	PART II OTHER S	GNIFICANT CONDITIONS	CONTRIBUTING	TO DEATH BUT NOT R	ELATED TO T	HE TERMINAL DISEASE CON	IDITION GIVEN I	PART 1(o)		PERFORMED? YES X NO
SICIAN: spital a errificate ed far	CERTIFICATION	200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	205.	DESCRIBE HOW INJURY	OCCURRED. (	Enter noture of injury in	Port I or Port II	of item 18.)		
	MEDICAL	Hour o	m. 1	9 Whi	ark 🔲 atwork 🗀	focto	E OF INJURY (Hame, form pry, street, office bldg., etc.)		ity or town)	(County)	
ENDIN ned by R: Affe uld be the Sto		21. I cert	ify that (1) (this h	aspital) atte	nded the decease	d fram , and that	26 Jun , 1 death accurred af	1967, to_ 5:53A.M, 1	2 Jul ram causes	, 19 <u>.67,</u> and an the c	that $\chi$ l) (we) last late stated above.
Page 4 may be retained by the haspital ar IO FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached for us shauld be filed with the State Dept. af Health		220. SIGNATURE	Uf Jan	ly		J.M	ATTENDING -	MED DIRECTOR	STAFE	22b. DATE S	
mar RAL		NAME (Type	W. J. F	MTY, C	DR MC USN					esda, M	d.
O HOSPITAL Page 4 may O FUNERAL ( director, pag shauld be fill	230	BURIAL, CREMATI	ON, 23b DATE	THEREOF 3-67	23c. NAME OF CE		CREMATORY CIZEMATORY	23d. LOCAT		TLAHO	md.
VR A15 (4)		. FUNERAL DIRECTO		HOME	ARLINGT	on, v	A DATE	UL 6 STRAR	1967sb RE	Sagges Her	TYPO LINEAR
	_										

MARYLAND STATE DEP Division of STATISTICAL RESEARCH AND RECORDS, 301		21201
0.0016	OF DEATH	00831
PLACE OF DEATH COUNTY MONTGOMERY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Resonant of the state of	nonte smery
b CITY OR TOWN (If outside carparate limits, write RUBAL and give nearest town)  it were Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside carparate limits, write RURAL and Calthersburg d STREET ADDRESS	e. IS RESIDENCE ON A FARM?
Holy CROSS Huspiral	R+ 3 B0x 178	YES ANO
3. NAME OF DECEASED (Type or print) Thomas Middle Michael	Miller OF DEATH July 11	Doy Year 19 6 7 NDER 1 YEAR   IF UNDER 24 HRS.
male white widowed Divorced J	lost burthday) Mont	
during most of working life, even it retired) INDUSTRYInfant	Maryland /	COUNTRY?
John Murlen Miller	Margic Ellen Darne	~
15. WAS DECEASED EYER IN _ S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of service)	NFORMANT Address Falker	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o)	urity-	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gove )	,	41 hrs.
nse to immediate cause (a), stating the underlying couse lost.    DUE TO   CC   CC   CC   CC   CC   CC   CC		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO
GR CONTRIBUTING CAUSE OF DEATH	Enter nature of injury in Part I or Part II of Item 18.)	
	E OF INJURY (Hame, farm, pry, street, office bldg., etc.)	(County) (Stote)
	deoth occurred at TPM, fram causes and c	
220. SIGNATURE - MD	ATTENDING MED DIRECTOR PHYS.	Pb. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) RAIPH Stiller M.D	22d. ADDRESS Spring St	reet S.S.
230 BURIAL (REMATION, BREMOVAI (Specify) 7/21/67 Cate of each care of the cate		(County) (Stote)
Burial 7/21/67 Gate of ea	aven Cemetery Silver Spri	ing. Md.



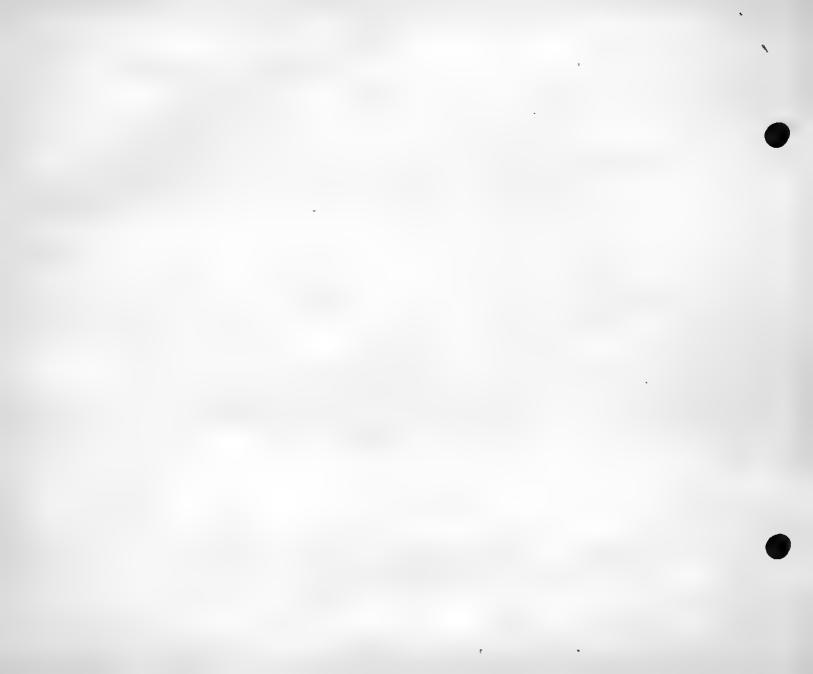
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 vovCERTIFICATE OF DEATH in by the funeral rs Pages 1 and 2 thours after death; PHYSICIAN: The law requires that the death certificate be executed within-34 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Montgomerv Montgomery Maryland MARYLAND b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (if gutside carparate limits, write RURAL and give negrest town) Silver Spring 47 days Bethesda within 72 ha d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? filter in The Clinical Center, Bethesda, Md. 20014 7502 Alfred Drive YES NO TX 3 NAME OF Middle 4 DATE First last Manth Year DECEASED complete and in ony event, (MMN) Millone (Type or pant) Salvatore July 67 DEATH 19 DATE OF BIRTH IF UNDER I YEAR IF LINDER 24 HRS 6 COLOR OR RACE 7. MARRIED 9. AGE (In years NEVER MARRIED Jast birthday) Manths Davs Haurs May 19, 1915 White WIDOWED Male DIVORCED and 10g JSUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician c ien please during most of working life, even if refired)
Tile Setter INDUSTRY **COUNTRY?** Italy USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, the attending phys Stefano Millone Leonarda Rapisardi WAS DECEASED EVER IN U.S. ARMED FORCES? The Medical Recordiess 16 SOCIAL SECURITY NO. (Yes, no, or unknown). It If yes give wor or dates at service signed by the atten buriol-transit permit buriol, cremation, a 214-34-6828 The Clinical Center, Bethesda, Md. No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per une for (a), (b), and (c) ) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Bronchopneumonia and purulent meningitis davs Conditions, if any, which gave (b) Metastatic carcinoma of the lung 4 months rise to immediate cause (o). DUE TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Poge 4 may be retained by the hospital or ottending has been be detoched for use as the State Dept of Health prior to last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(g) 19 WAS AUTOPSY PERFORMED? Urinary tract infection YES 🖓 NO TO FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS LINDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (City or town) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (County) (State) Nat While Haur o.m. factory, street, affice bldg, etc.) at work ot work 21. I certify that (4) (this haspital) attended the deceased from May 19 , 19 67, to July 5 , 19 67 that (1) (we) last saw the deceased alive an July 5 19 67, and that death accurred at 6:25 M, from causes and an the date stated above. director, page 3 should should be filed with the 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** X 5 July 1967 M.D. PHYS 22d ADDRESS The 22c PHYSICIAN'S Clinical Center, National of Health, Bethesda, Md. NAME (Type) Charles M. Haskell. MD Institutes 23 NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (State) 23a BUR AL, CREMATION, (Caunty). REMOVAL (Specify) REGISTRARS SIGNATURE FUNERAL DIRECTOR 25a REC D BY REGISTRAR VR A15 (4) 25M 1/67



1	MAKTLAND STATE DEPARTMENT OF HEALTH  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
delay is and 3 to M3. Page rtmint of	o. COUNTY MONT TOINNETY MARYLAND O. STATE MOSYLAND COUNTY MOINTAGE MOSYLAND
4 2 d	b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 1b - C CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)
on on M3.	write RURAL and give nearest town)  Faithers burg
Depar	d NAME OF HOSP TAL OR INSTITUT ON (If not in hospitol, give street oddress)  d STREET ADDRESS  e IS RESIDENCE ON A FARM?
frer death If any de Give Pages 1, 2, and long with form PM3.	11 Chestnut - Street. 11 Chestnut Street - YES NO
Pog Hith of S	3 NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED OF OF
fer do Give ong w	(Type or print) NETTIE MEC. MORATEL DEATH 00/4 - 19 196/.
24 hours after deoth 1 in Item 18. Give Pages r's Office along with for stand 2 AMT The State lifter deot.	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years   FUNDER 1 YEAR   IF UNDER 24 HRS   Iost birthday) Months Doys Hours Min
d d d	7 c W WIDOWED D VORCED Dec. 15, 1892 74 VIS MONTHS OUTS MINI
ho Off	100. USUAL OCCIPATION (Give kind of work done during most of working ite, even if retired) / INDUSTRY 11 BIRTHPLACE (State or foreign country) 12 (ITIZEN OF WHAT COUNTRY) 13 COUNTRY)
thin 24 hours notil in Item 3 niner's Office pages 1 and 2 urs after deor	13 FATHER'S NAME  14 MOTHER'S MAIDEN NAME
within pencil xominer ile page hours a	Bizdley Norward Margaret Trail
d with per Exon Exon File	15 WAS DELEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT 3 Address 1018 ACOUNTY
xecuted nding" in Medicol E permit. I	(Yes, no, or unknown) (If yes give wor or dates of service) 5-77-32-7420 Thomas hours how not nockarble hid
ficote should be e ing the word "per ded to the Chief i as o buriol transit ond in ony event i	8 CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c))  PART I. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (o)  Cofold organization, which gove rise to immediate cause (o).  Stoting the underlying couse (c)  (c)  INTERVAL BETWEEN  SONSET AND DEATH  SOUTH TO SOUTH TO SOUTH TO SOUTH TO STORY TO SOUTH
: This certi Tificote, writ Id be forwor Jid be used or removol,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)  19 WAS AUTOPSY PERFORMED? YES \( \sum \) NO
#=	PRIMARY Or CONTRIBUTING CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH AND INJURY OCCURRED (Enter nature of in ury in Port I of term 18.)
EXAMINER: unte the certi oge 4 shoulc your files. Poge 3 shou	20c TIME OF JURY Month, Day, Year While Not While of work of w
At EXA execute r. Poge . I for you for: Pog	21. I certify that 1 taak charge of the remains described above, held an Autopsy 🔲, Inspection 🔀, Inquiry 🔀, and 'n my opinion
Se executor. Pour for the formed for the formed for burnel, burnel,	death resulted fram: Natural causes 📈, Accident 🗌, Suicide 🔲, Homicide 🔲, Undetermined manner 🔲
MEDICAL EXAM please execute the I d'rector. Page 4 retained for your EDIRECTOR: Page or to bur al, cremo	ACTUAL () & Ball CHIEF MEDICAL EXAMINER () 22, DATE SIGNED
Y N Plant of definition	SIGNATURE  M.D. ASSISTANT MED CAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDI
o DEPUTY MEDICA necessory, please ex the funerol director. 5 may be retained for the funeral DIRECTO	EXAMINER'S NAME (Type)  John G. Ball  Address (Street, city, town, or county)
necessory, please extre funeral director.  5 may be retained from From the funeral director.  From Funeral Director.  Health prior to bur a	230 BUR AL (REMATON, 23b DATE THEREOF 23c NAME OF CEMETERY OR (REMATORY 23d LOCAT ON (Gry or Town) (County) (Stote)
VR A15ME (5) 6 %	24 FINERAL DIRECTOR Ernest C. Gartner ADDRESS 250. RECD BY REG STRAR 25b REG STRAR S SIGNATURE Surge Strange S
' )	- Comment of the second of the



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before galmission) p. COUNTY MARYLAND in by the Pages c LENGTH OF STAY IN 1b nit. Then please temave carban papers. Page ar remaval, and in Jay event, within 72 hours at d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled i 4. DATE OF DEATH and completely fremave carban 3. NAME OF M.ddle Year Day DECEASED 19 60 (Type or print) S. SEX 9. AGE (In years 7. MARRIED NEVER MARRIED B. DATE OF BIRTH JE UNDER 1 YEAR IF UNDER 24 HRS lost\_birthday) WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if getired) Housewh 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service burial, crematian. 18. CAUSE OF DEATH (Enter only one cause per line far (a) (b), and (c) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause director, page 3 shauld be aeracnea not ove we thank briar to should be filed with the State Dept. of Health priar to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES T NO 🔽 certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 20a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day Year Hour o m 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (C ty or town) (County) (Stote) While at work I not While factory, street, affice bldg, etc.) O HOSPITAL OR ATTENDING O FUNERAL DIRECTOR: After 21 I certify tha (1) (this haspital) attended the deceased fram. \_\_\_, that (I) (we) last 19 667 ta 7/21 19 67, and that death accurred at SCA M, from causes and an the date stated above saw the deceased alive an 22d SIGNATURE 22b. DATE SIGNED DIRECTOR M.D 22d ADDRESS 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL CREMATION DATE THEREOF (County) Cremation Cedar Hill Crematory Suitland, Maryland 7-24-67 24. FUNERAL DIRECTOR **ADDRESS** 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 PUMPHREY, Bethesda, Maryland



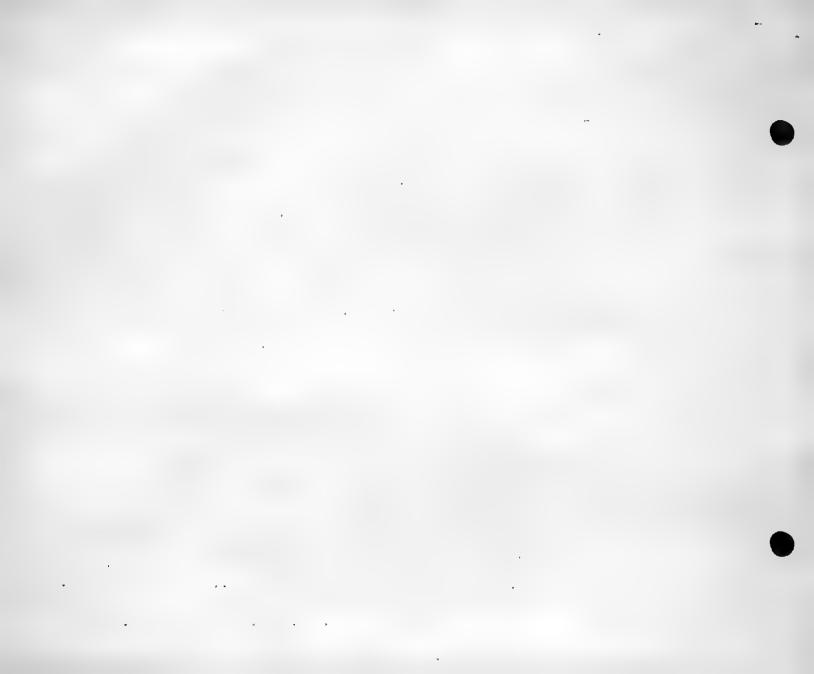
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09820 09825 CERTIFICATE OF DEATH hours after deoth. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY COUNTY MARYLAND c. LENGTH OF STAY IN 1b c CITY OR TOWN (if outside corporate limits, write RURAL and live nearest town d. NAME OF MOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 5509 □ NO 🗷 YES NAME OF Middle 4. DATE Month Last Doy Year DECEASED rread (Type or pont) DEATH 19 G event, PHYSICIAN: The low requires that the death certificate be executed comple IF JNDER 24 HRS SEX 9. AGE fln years IF UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH lost birthdov) Months Dovs Hours WIDOWED 📉 and in ony DIVORCED puo 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRIHPLACE (County & State, or foreign country) during most of working ite, even if retired) INDUSTRY COUNTRY? physician 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or removal, IS WAS DECEASED EVER IN U.S. ARMED FURCES?
(Yes, eo, or unknown) (If yes give wor or dotes of service) INFORMANI 16. SOCIAL SECURITY NO. 17 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) buriol-transit PART I DEATH WAS CAUSED BY MMEDIATE CAUSE (0) the hospital or attending physician. DUE TO Signed buriol, ( Conditions if only, which gove use to ammediote couse (o), DUE TO stating the underlying couse os the prior to last. 19. WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detached for use State Dept. of Health NO certificate 20g. ACCIDENT WAS LINDER LYING □ 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port I, of stem 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, (County) 20d INJURY OCCURRED (City or town) (Stote) Hour om. factory, street, office bldg , etc ) While Not White at work at work be retained by 21. I certify that (I) (this haspital), attended the acceased fram. that (I) (we) iasi O FUNERAL DIRECTOR: , and that death accurred at 10 12 M, from causes and an the date stated above saw the deceased alive an 220 ISIGNATURE 22b DATESIGNED ATTENDING STAFF DIRECTOR . director, page 3 should be filed v M.D PHYS PHYSIC ANS 22d\_ADDRESS O HOSPITAL NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF LOCATION (City or Town) 230 BURIAL, CREMATION, (Stote) TEMOVAL-TS PACTY) 7-1.0-67 Parklawn Cemetery Rockville Maryland ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md

Horner . Characa & Da

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O COUNTY o STATE 6 COUNTY Montgomery
b CITY OR TOWN (If auts de corporate limits, MARYLAND Maryland Prince George c LENGTH OF STAY IN 16 c CITY OR TOWN ( f autside carparate limits, write RURAL and give nearest town) puo THE PURAL amp ave Regrest town) 12 hours Hvattsville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Give Pages 901 Chillum Court Washington Sanitarium and Hospital YES NO THE Office along with 3 NAME OF Middle 4 DATE Manth DECEASED (Type or print) DEATH Esther 7-31-67 Jean IF UNDER 1 YEAR IF LINDER 24 HRS 6 COLOR OR RACE 7 MARRIED B DATE OF BIRTH 9 AGE (In years NEVER MARRIED last birthday) Months Hours ony event within 72 hours ofter deoth Negro DIVORCED 3-23-35 female 10a USUAL OCCUPAT ON (Give kind of work done 106 KIND OF BUS NESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Social Worker Illinois America pencil This certificate should be executed within 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Raymond McFerren Ollie Lewis IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dales of service 17 INFORMANT 16. SOCIAL SECURITY NO word "pending" ir the Chief Med cal I Patent's chart no 18 CAUSE OF DEATH (Enter only one couse per ne for to INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY ONSET AND DEATH - IMMEDIATE CAUSE (a) e, writing the word forwarded to the Ch DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause last. or removal, PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS 200 EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) PRIMARY ar CONTRIBUTING CALISE DE DEATH 20c I.ME OF NJLRY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form 20f (City or town) (County) Not While Haur a.m. factory, street, office bldg, etc.) moy be refained for your FUNERAL DIRECTOR: Page While at wark 21 I certify that I took charge of the remains described above, held an Autopsy 17. Inspection 1 Inquiry A and in my apinian Natural causes Acadent death resulted from Hamicide Suicide Undétermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER TO DEPUTY 5 moy 1 O FUNE! Heolth Alleres Kirker Gent Call Will ar county) 230 B IRIAL CREMATION 23d LOCATION (City o REMOVAL (Specify) Harmony Meo, Park Prince/George Lowe's Funeral Home ADDRESS 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1/67 1425 Md. Ave, N. E. D. C.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09822 C5883.1 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF GEATH o. COUNTY o. STATE b. COUNTY Maryland Montgome rv ve carbon papers. Pages I eyent, within 72 hours after Montgome ry MARYLAND b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate rimits, write RURAL and give nearest town) write RURAL and give necrest tawn) Silver Spring Fairland - Rural filled in by d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. .S RESIDENCE ON A FARM? 801 Seeks Lane Fairland Nursing Home YES NO [X] 3. NAME OF 4. DATE Year DECEASED 1967 TERESA E. MULLICAN July 4. 19 (Type or pnnt) DEATH 6 COLOR OR RACE AGE ( n years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED B DATE OF BIRTH NEVER MARRIED last birthdoy) Hours March 7.1882 White Female WIDOWED DIVORCED burial, cremation, or remaval, and in an the attending physician and isit permit. Then please ren 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 10o, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE COUNTRY? INDUSTRY Maryland TISA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Catherine Dean Schultz 16. SOCIAL SECURITY NO 17 INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES? signed by the attendir burial-transit permit. (Yes, no, or unknown) {If yes give wor or dates of service F. Dean Mullican-Item # 220-48-0968 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse **J FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept of Health priar ta lost. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO S 200 ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While of work 21. I certify that (1) (this hospital) attended/the deceased from... and that death accurred at 2145 M, from causes and on the date stated above saw the deceased alive on 22b. DATE SIGNED 220 SIGNATURE ATTENDING DIRECTOR PHYS. PHYS 22d. ADDRESS 22c PRYSICIAN'S Scott Dr., Silver Spring, 359 NAME (Type) Norman H. Rubenstein 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 230 BURIAL, CREMATION, REMOVAL (Specify) 7/6/67 Colesville deth. Ch. Cem. Colesville, Md. 9 24 HUNERAL DIRECTOR
Tyson Wheeler Funeral Home-1331 Pockville Pike 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 196 20 M 1/66 Rockville .lid.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 99823 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death ond USUAL RESIDENCE (Where deceased lived of institution: Residence before admission) the attending physician and campletely filled in by the funeral sit permit. Then please remave carban papers. Pages I and PLACE OF DEATH a. COUNTY n STATE b. COUNTY Montgomerv Maryland MARYLAND Montgomery b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (if outside corporate limits, write RURAL and give negrest tawn) papers. Per Nin 72 haurs Rural - Lewisdale Rural- Lewisdale e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS RFD. Monrovia YES NO R.F.D. Monrovia <u>~</u> Middle 4 DATE NAME OF DECEASED Urner DEATH R. Mullinix (Type or print) July 9 AGE (in years IF LINDER 24 HRS. SEX 6 COLOR OR RACE 7. MARRIEO NEVER MARRIED 8 DATE OF BIRTH last birthday) Months Covs Hours WIDOWEO Male White June 7.1890 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JOB. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Brick laver Lewisdale Md.

14 MOTHER'S MAIDEN NAME TISA 13. FATHER'S NAME Sherman Mullinix Annie D. Mullinix 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give war or dates of service) Yes 214-14-4378 Mrs E. Rena Mullinix. Item 2 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma of INTERVAL BETWEEN signed by the burial-transit p Carcinoma of the Lung 1 ONSET AND DEATH Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove nse to immediate couse (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. of Health priar to 19 WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Renal Disease NO X YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I ar Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING C CAUSE OF DEATH No accident involved (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Ooy, Year foctory, street, office bldg., etc.) Hour o.m. Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from April 5. , 19 67, to July 29. , 167, that (I) (33) last saw the deceased alive on July 29. 19 67, and that death occurred at 6:00M, from causes and on the date stated above shauld be saw the deceased alive on July 29, 22b. OATE SIGNEO 22a, SIGNATURE 2, M.D. ATTENOING PHYS MED. STAFF DIRECTOR PHYS □July 30, 1967 22d. AODRESS 9701 Church Street M. McKendree Boyer. 22c. PHYSICIAN'S NAME (Type) Damascus, Maryland, director, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 230. BURIAL CREMATION. REMOVAL (Specify) July 31,1967 Browningsville. Md. Burial Bethesda Meth. 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE AUG 196/ VR A15 (4) 20 M 1/66 Olin L. Molesworth, Damascus, Md.

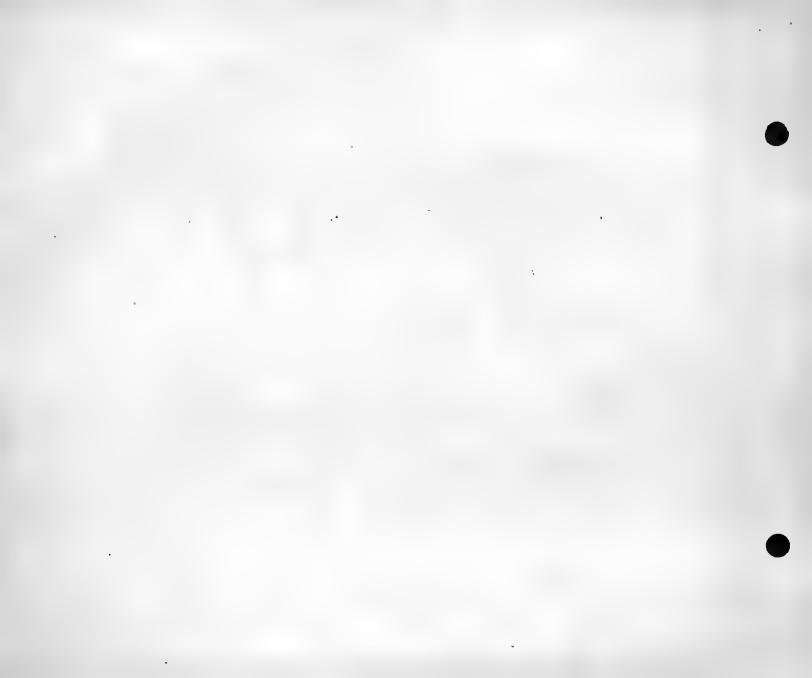


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 39824 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death ly filled in by the funeral san papers. Pages I and within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) c. COUNTY g. STATE b. COUNTY Montgomery Virginia MARYLAND Arlington ' b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate timits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 10 days Arlington Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)2007 / B IS RESIDENCE ON A FARM? d STREET ADDRESS 2918 South 20th Street The Clinical Center, Bethesda, Maryland YES NO IX NAME OF 4. DATE First Lost Month reprove carbon Year DECEASED (Type or print) OF DEATH Kathryn Adolphus Mullins 1967 July 6. COLOR OR RACE B DATE OF BIRTH AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED X X NEVER MARRIED lost birthdoy) Months Dovs Hours Female Negro WIDOWED DIVORCED October 1930 pub 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Service IISA Georgia 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar remayal, Juanita Curtis John B. Williams 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT The Medical Record Address (Yes, no, or unknown) (If yes give wor or dates of service) 228-42-4604 The Glinical Center, Bethesda, Maryland 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (o) Cryptococa. signed by the burial-transit g 2 Weeks Meningitis Cryptococcal DUE TO Conditions, if ony, which gove Hodgkins Disease 6 months rise to immediate couse (a). DHE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Heatth prior to lost. 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Carcinoma of the cervix YES JK NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of Item IB) 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (County) (Stote) Hour om fectory, street, office bldg , etc.) Not While of work at work O HOSPITAL OR ATTENDING 21. I certify that 10 (this haspital) attended the deceased from 21 June \_\_\_\_\_, 1967 to 1 July \_\_\_\_, 1967, that (A) (we) last Page 4 may be retained saw he deceased alive an 1 July 1967, and that death accurred at 11:10M, fram causes and an the date stated above 22b. DATE SIGNED STAFF ATTENDING [X] 2 July 1967 M.D. DIRECTOR 22d ADDRESS The Clinical Center, National 20 CAPHYSICIAN S NAME (Type) Dan C. Bird, MD Institutes of Health, Bethesda, Md. 236 DATE THEREO NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION 23d LOCATION (Gity or Town) REMOVAL (Specify) FUNERAL DIRECTOR VR A15 (4)



. 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
		09825 CERTIFICATE OF DEATH	GSC	50		
law requires that the death certificate be executed within 24 haurs after death nding physician. been signed by the attending physician and completely tilled in by the foneral s the burial-transit permit. Then please remave carbon papers Pages in to burial, cremation, ar remaval, and in any event, within 72 hours after death		PLACE OF DEATH  a. COUNTY  MARYLAND  2 USUAL RESIDENCE (Who	ere deceased lived, if institution. Residence b	efore admission)		
haurs after by the sees shours affer a haurs a h		SILVER SPRING approx 3 Mag. Was	de corparate limits, write RURAL and give nei			
ithin 24 h	5	d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give Greet oddress)  JUNION MANCE HEALTH CAFE CENTER 4600 - 4	45 MINW	e IS RESIDENCE ON A FARM? YES NO		
d withi		NAME OF DECEASED (Type or print) FRANCES E. MURPHY	DEATH JULY	9 1967		
executed w d complete emave carb any event,		SEX 6 COLDR DR RACE 7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH FRANK WIDOWED   NEVER MARRIED   8. DATE OF BIRTH FRANK WIDOWED   APR. 12 187	9. AGE (In years   IF UNDER 1 YE) 9 (ast birthday) 16 9 (Ast birthday) 17 (Ast birthday) 18 (Ast birthday) 19 (Ast birthday) 10 (Ast birthday) 10 (Ast birthday) 10 (Ast birth	ys Haurs Min		
ate be executicion and comilease remave	dur	ring mast of working ide, even if retired) from INDUSTRY - KANSA	State, or foreign country) 12. CITIZEN COUNTI	OF WHAT RY? U.S.		
certificate ( physician then please naval, and	13.	FATHER'S NAME  Hallgrave  14. MOTHER'S MAIDEN NAI  TER	ESA ?			
ne death cer attending p permit. The ion, ar rema	1S. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT	ELLBRING DICKER	ESON. MD.		
equires that the death certific physician. signed by the attending physi burial-transit permit. Then pl burial, cremation, ar remaval,		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (d.) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Lene broad The parties	sie	INTERVAL BETWEEN ONSET AND DEATH		
equires that t physician. signed by the burial-transit burial, crema		Conditions, if any, which gave ) DUE TO Some Pale as	<i>y</i>			
e law requirending phosphale signer signer to but prior to but prior to but		rise to immediate cause (a), stating the underlying cause last.				
TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health prior to	ATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDI	TION GIVEN IN PART \$(a)	19 WAS AUTOPSY PERFORMED? YES NO		
PHYSICIAN: The e hospital ar atte his certificate has stacked far use a Dept, af Health pr	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	rt 1 or Part II af item 18.)			
JING PHYS by the hos after this ce be detache State Dept.	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, While at wark at wark at wark 20d Injury occurrence)	20f. (City or town) (County)	(State)		
ATTENDING stained by the CTOR: After I should be dirth the State		21   certify that (1) (this haspital) attended the deceased from 111 3, 196	to 111 9, 196/	, that (I) (we) las date stated abave		
OR ATTENI be retained DIRECTOR: A le 3 shauld ed with the		Months of the Mo. PHYS LAT DI	ED STAFF 22b. DATE STAFF PHYS.	SIGNED 7		
D HOSPITAL OR ATTENI Page 4 may be retained D FUNERAL DIRECTOR: A director, page 3 shauld shauld be filed with the		22x PHYSICIAN'S NAME (Type) OBERT T. THIBHDEAU KOCKUI	12E MD 208.	5-2		
O HOSPITAL Page 4 may O FUNERAL I directar, pag shauld be fil	230	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY, REMOVA (Specify)  LICENT CEM.	23d. TOCATION (City or Town) (Col	D (State)		
VR A15 (4)	24	4 FUNERIL DIRECTOR ADDRESS COMPANY DATE	REGISTRAR 1967 REGISTRAR'S SIGN	ATURE Judges		



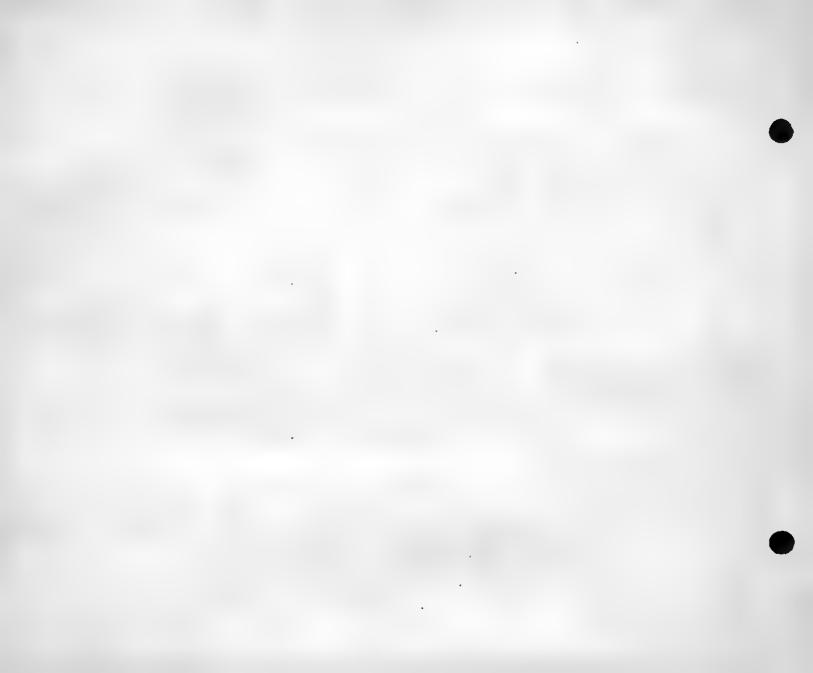
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a. COUNTY MONTO, NCK MARYLAND The law requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (If ourside carparate limits c. LENGTH OF STAY IN 15 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) ely filled in boan papers. d NAME OF FIOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDEN ON A FARM 70 NO V YES carban NAME OF Last Year OF DECEASED event, (Type or print) MER MI DEATH 19 IF UNDER 1 YEAR AGE (In years 6 COLOR OR RACE 7. MARRIED **NEVER MARRIED** remaye last birthday) 18 CAUC DIVORCED and 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? IN AShin. FIRT ING BullSME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, WAS DECEASED EVER IN L.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates of service 18. CAUSE OF DEATH (Enter-only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY brouder IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires th Page 4 may be retained by the haspital ar attending physician DUE TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause as the prior tat has been last. WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) be detached far use State Dept. af Health manue strake NO TO FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, form, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED (County) Hour a.m. factory, street, affice bldg., etc.) at work 21. I certify that (1) (this hospital) attended the deceased from 1960 meun July 1967, and that death accurred at 2 f M, fram causes and on the date stated above saw the deceased alive an 22a, SIGNAJURI 22b. DATE SIGNED **ATTENDING** directar, page 3 shauld be filed v M.D DIRECTOR PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION 23b DATE THEREO (State) Gate of Heaven Cemetary Silver ADDRESS 250 RECD BY REGISTRAR 196755. 24. FUNERAL DIRECTOR VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) PLACE OF DEATH **b** COUNTY o. COUNTY MARYLAND c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 1b b. CITY OR TOWN (1 outside corporate infits. write RURAL and give nearest town d STREET ADDRESS OR SHALLING HE BOL Hospitok Give Circle didices con ter NAME OF DATE Year Middle DECEASED OF DEATH 19 67 (Type or print) S. SEX 6 COLOR OR RACE 7 MARRIED / last birthday) WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ellen Best Robertz 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) Harold A. Neff-259 Congressional Lan ROCKVILLE, Mahiterya, BETWEEN TB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DUE TO ARTERIO Schopotic Heart Disease Conditions, if any, which gove rise to immediate couse (o). DUF TO stoting the underlying couse lost. WAS AUTOPSY PERFORMED? PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Cerebro Vescular NO X 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (State) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) Not While factory, street, office bidg , etc.) of work at work O FUNERAL DIRECTOR: After 2). I certify that (1) (this haspital) attended the deceased fram July 10 19 62, and that death accurred at 935 M. Hon. Spases and an the date stated above saw the deceased alive an\_ 22b DATE SIGNED 220 SIGNATURE MED DIRECTOR M D director, page shavid be filed 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23d. LOCAT ON 4City or Town) 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, REMOVAL (Specify) Prince Georges Co. Lincoln Cemetery 250 REC D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 1967 DATUUL 24



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) o. STATE o. COUNTY b. COUNTY: MARYLAND b CITY OR TOWN (If outside disporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give neglest town) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street odgess) IS RESIDENCE ome NO 4 DATE NAME OF Middle Month Year and campletely DECEASED OF DEATH 0485 arlo 1967 (Type or print) IF UNDER I YEAR IF UNDER 24 HRS SEX AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH lost birthdoy) Months Dovs Hours 8-18-/Aup ui WIDOWED DIVORCED 12 CIT ZEN OF WHAT 100 JSUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even it retired) INDUSTRY COUNTRY? and Baltimore ontroller et 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Lecomolive Works or removal, attending phy permit. Then INFORMANT 16 SOCIAL SECURITY NO (Yes, no. or unknown) (If yes give wor or dates of service) 3-09-490 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attedirector, page 3 shauld be detached for use as the burial-transit perreshould be filed with the State Dept. of Health priar to burial, cremation, THE REAL PROPERTY. 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19. WAS AUTOPSY PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT PRIATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) PERFORMED? ance NO YES 🗀 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of inputy in Part I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While of work M. Ham suses and an the date stated above 22b. DATE SIGNED 220. SIGNATURE **ATTENDING** director, page 3 should be filed v M.D. DIRECTOR 2YH9 22d. ADDRESS 22c. PHYSICIAN'S LOCATION (City or Town) BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) 250. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09829 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. campletely filled in by the funeral ave carbon papers. Pages 1 and 5 y event within 72 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) p. COUNTY b. COUNTY Montgomery Maryland MARYLAND b CITY OR TOWN (If outside corporate emits, write RURAL and give nearest fown)
Bethesda (rural) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 Lexington Park 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENC ON A FARM? 483 Chinlee Drive Naval Hospital YES NO DE NAME OF Middle 4 DATE Lost Month Year remove carban Day DECEASED O'CONNOR. JR. July 10 (Type or print) James DEATH 19 burial, cremation, ar removal, ond in any even IF UNDER 24 HRS IF UNDER I YEAR 6 COLOR OR RACE 8. DATE OF BIRTH AGE ( n years 7 MARRIED NEVER MARRIED lost birthdoy) Months Hours Male Cauc. WIDOWED DIVORCED May 13, 1935 10a LSCAL OCCUPATION (Give kind of work done TOD. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
U. S. Navy INDUSTRY COUNTRY? Orange. New Jersey USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Dorothy Egan James Francis O'Connor 17 INFORMANT Lexington Park 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. Address New Jersey (Yes, no, or unknown) (If yes give war or dates of service) 1955-1966 144-26-9900 Mrs. Arlene O'Connor, 483 Chinlee Drive 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit p Embryonal Carcinoma right testicle with ONSET AND DEATH IMMEDIATE CAUSE (o) multiple metastases. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse the last. OS O WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES (X) NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (Stote) 20c TIME OF INJURY Month Doy, Year Not While factory, street, office bidg , etc.) of work of work **DIRECTOR:** After 21. I certify that \$\pi\$) (this haspital) attended the deceased from June 15 saw the deceased alive on July 10 1967, and that death accurate to July 10 \_, 1967 , that \$1) (we) lost TO HOSPITAL OR ATTEND Page 4 may be retained saw the deceased alive on July 10 , and that death accurred of 620PM, fram causes and on the date stated above. 220 SIGNATURE 22b DATE SIGNED **ATTENDING** MED DIRECTOR 12 July 1967 X MD PHYS 22c PHYS CIAN'S 22d. ADDRESS TO FUNERAL Naval Hospital, Bethesda, Md. NAME (Type) B. Blanchard 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BUR AL CREMATION (Stote) (County) Burlal Transit Arlington Natl Cem. Arlington, Virginia 7-17-67 ADDRESS 250 REC D BY REGISTRAR 25h REG STRARY SIGNATURE 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsing VR A15 (4) 25M 1/67 Ave. Bethesda Md.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09830 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Montgomery **b.** COUNTY o. STATE MARYLAND Maryland Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

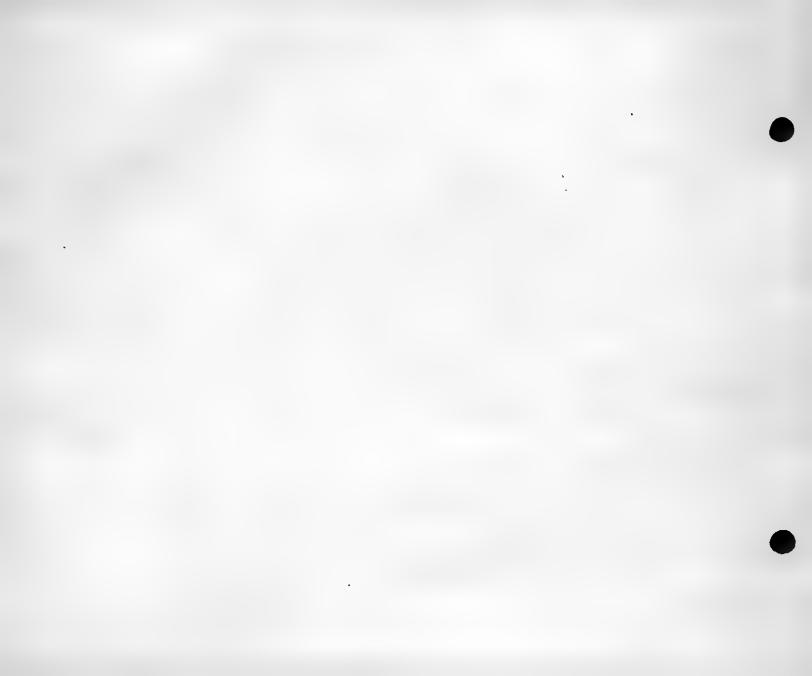
Chevy Chase c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) hours aft c. LENGTH OF STAY IN 16 The low requires that the deoth certificate be executed within 24 hours Chevy Chase IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 4701 Willard Avenue NOXX 4701 Willard Avenue YES NAME OF Middle 4 DATE Month First Last Year and completely DECEASED (Type or print) 19 (3 ent, RUTH ELIZABETH OCHS DEATH IF UNDER 24 HR 9. AGE (In years SEX 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH NEVER MARRIED ottending physicion and comported in the please remove Gast birthdoy) Months Dovs Hours White 7-14-1903 Female WIDOWED DIVORCED burial, cremotion, or removal, and in ony 100) USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) Virginia
14. MOTHER'S MAIDEN NAME Secretary
13. FATHER'S NAME JGS, Adolph Volk Mamie Johnson 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO APPROVED (Yes, no, ar unknown) (If yes give wor or dates of service 577-60-0352 Karl W. Ochs-See Item #2. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burnal-tronsit p ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Page 4 may be retoined by the haspital or attending physician. DUE TO Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO stating the underlying couse prior to l os the last .NOTIFIED WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Stote Dept. of Health NO.XIX 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B) 20o ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20f. (City or town) 20e PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED EXAM. foctory, street, office bldg., etc.) Not While of work DIRECTIIR: After 1967, that(1) (we) last 21. I certify tha (1) (this haspital) attended the deceased fram director, page 3 should shauld be filed with the 1967, and the death occurred at 740 P.M. from causes and an the date stated abave. /8 Kulle say the deceased alive an KED. DATE SIGNED 220. SLOWATJR ATTENDING MED DIRECTOR M.D PHYS 22d ADDRESS REAP, TO FUNERAL 9241 COLUMBIA BUM NUME (Type) DAMES SPRING. Md 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 230. BURIAL, CREMATION, 23b DATE THEREOF Suitland 7-26-1967 Cedar Hill Gawler's Sons, Inc.



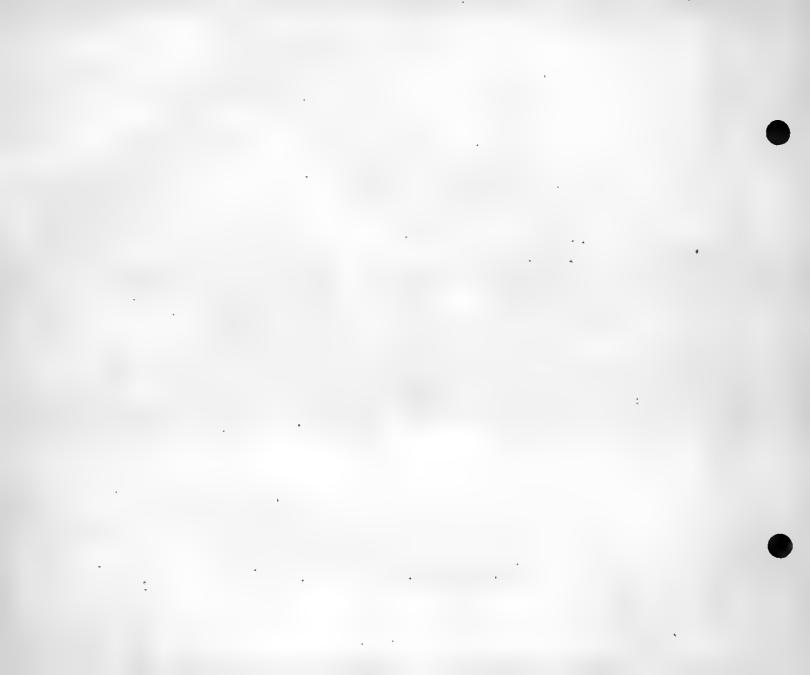
	MARYLAND STATE DEPARTMENT OF HEALTH	
o <sub>l</sub>	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLA  CERTIFICATE OF DEATH	2838
1.	1. PLACE OF DEATH	a bafora admissio
	montgomery MARYLAND STATE maryland b. county montg	201411
	b. CITY OR TOWN (if outside comporate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown)	earast town
	Bethesda Rockville	a. IS RESIDEN
	1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ON A FAR
	3. NAME OF First Middle Last 14. DATE Month Day	Yasr
	DECEASED (Type or print) Baby Boy O'Dell DEATH July 4	1967
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years W UNDERLYEAR last birthday) Months Days	IF UNDER 24 H
	10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country)   12. CITIZEN O	F WHAT COUN
	dona during most of working life, even if relired) montanners and U.	Sa
	13. FATHER'S MAIDEN NAME	,
	Jack walter O'Dell Ophelia Rodriguez Kerez	
	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yas, no, or unknown) (Ifyas giva war or dales of service)  Address  Address  Address	1 116
	18. CAUSE OF DEATH Enter only one cause per line for lat. by, and (ct.)	ERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) CITED STATES THE MALLEL	SET AND DEAT
	DUE TO L	this 20
	Conditions, if any, which (b) Puttattling gave rise to immediate cause	-
	(a), stating the undarlying DUE TO	
	Z PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BL RELATED TO THE TERMINAL DISEASE CONDITION . N IN PART 1(a), 1	9, WAS AUTO
3	3 8	YES NO
	20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY ( JRED, (Enter nature of injury in Part I or Part II of fam 18.)	
		(State
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRE. 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County)  Hour a.m., While Not While factory, streat, office bldg., alc.)  p.m. 19 at work at work	
	21. I certify that (I) (this hospital) attended the dece. ed from. 71.4	hat (I) (we)
	saw the deceased alive on	ate stated at
	228. SIGNATURE CE STAFF PHYS. DIRECTOR PHYS. DIRECTOR PHYS.	226. D/
1	22c. PHYSICIAN S 22d. ADDRESS	1111111
1	NAME (Type) Fdward W. Feioli   11/25 ROCKUILLE PIRI: ROCKU	7205
	238. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 7/6/67 ROCKVILLE, Md.	(Stata)
1	24 FUNERAL DIRECTOR'S SIGNATURE TYSON Theeler Juneral Home 13:15 Rockvil'e Pike 25a. REC'D AY REGISTRAR, 25b. REGISTRAR'S SIGNATURE	TURE
	Rockville, Marylandone	0
	7	



	· .	Ιt	ems 18&21 Film 391 8-11-MARYLAND STATE DE	PARTMENT OF HEALTH	
	1		Division of STATISTICAL RESEARCH AND RECORDS, 30	1 W. PRESTON STREET, BALTIMORE, MARYLAND 21	201
17.96	FOR STATE		09832 MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	.0377
1	HEALTH DEPT.	1.	PLACE OF DEATH O COUNTY  MESSO + ALONG OF MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Reside to STATE to COUNTY	nce before admission)
	n PM3. Page hepartness of the contract of the		b CITY OR TOWN (If outside corporate limits) of LENGTH OF STAY IN 16 write ROTAL and give nearest town)	C CTY OR TOWN Of autside corporate limits; write RURAL and give	/e nearest town)
	th If any gas 1, 2, h farm P tate Departments aft		d NAME OF HOSPITAL OR INSTITUTION (final in hospita, give street address)	d STREET ADDRESS	e S RESIDENCE ON A FARM? YES NO
	d within 24 haurs ofter death If in pencil in Item 18. Give Pages 1, Examiner's Office along with farm File pages Land with the State De and in any event within 2 haurs	3	NAME OF DECEASED (Type or prot)  NAME OF DECEASED (Type or prot)	OSI 4 DATE Month OF DEATH A COLUMN	Day Year 30 1967
	24 haves ofter death in Item 18. Give Page r's Office along with fest lands with he statement with he statement with he statement within 2 hours	5		B DATE OF BIRTH  9 AGE (In years   MUNDER lost burthdoy)   Months	42
	thin 24 haurs and in Item 11 miner's Office pages Land22 in any event	ID:	. USUAL OCCUPATION (Give kind of work dane ing most of working life, every freitred)  10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or fareign country) 12 C	ITIZEN OF WHAT
	ithin 2 sencil ir aminer' e pages d in an		FATHER'S NAME	14. MOTHER'S MAIDEN NAME	(
	executed with anding" in per Medical Exar permit. File imaval, and	15 (Y	WAS DECEASED EVER N.U.S. ARMED FORCES? IS, no, ar unknown) (If yes give war ar dates of service)	INFORMANT Address	
	d be executed within d' "pending" in pencil Chief Medical Examine transit permit. File pagi		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary infar	rction	INTERVAL BETWEEN ONSET AND DEATH Sudden
	thinker: This certificate shauld be executed within 24 haurs ofter death. If the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 4 shauld be forwarded to the Chief Medical Examiner's Office along with farm ur files.  If a shauld be used as a burial-transit permit. File pages I and with the State Deigent, prior to burial, cremation, ar remaval, and in any event within 22 haurs		Conditions, if ony, which gove isselt a immediate cause (a), stoling the underlying cause lost.  DUE TO  (b) Mural thrombosi  DUE TO  (c)	is Rt. atrium	Years
	his certificate, writing forward to be used to burial	FICATION	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES DE NO
	INER: This is certificate shauld be files. 3 shauld be as shauld be ant, priar to	E81	2Du EXTERNA, CAUSE WAS PRIMARY □ OF CONTRIBUTING □ CAUSE OF DEATH	(Enter nature of injury in Port 1 or Part 1 of item 18)	
	EXAMINER: T cute the certific age 4 shauld b r yaur files. Page 3 shauld ed agent, priar	MEDICAL	2Dc TIME OF N.JRY Manth, Day, Year 2Dd IN.JRY OCCURRED 20e P.A. Haur a.m. p.m. 19 While at wark at wark	ACE OF IN. URY (Hame, form, 120f (City or town) (Cotary, street, affice bldg , etc.)	ounty) (State)
4	2 2 4 5 K		21. I certify that I took charge of the remains described above, he	eld an Autapsy 🔀 Inspection 🔀 Inquiry 🔲, cide 🔲 Undetermined monner	and in my apinian
•	JIV MECKANY, please e eral director be retained RAL DIRECTOR Its design or its design.		ACTUAL SIGNATURE SIGNATURE	CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
	o DEPUTY necessary, the funera 5 may be 0 FUNERAI		EXAMINERS: JCh 2 J. R. J. C. D. S. NAME (Type) 7 D. J. C.	DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	3067
	101 105 105 105 105	23	BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR SUNFRA DIRECTOR ADDRESS	emetery Poolesville	Monta Ma
	VR A15ME (S. 6M 1/66		Obert K. Snowben Rockville,	Md DATE AUG 7 1967 yello	res Juage



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09833 CERTIFICATE OF DEATH PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest (5wn) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS a. IS RESIDENCE ON A FARM? executed within 24 = No 🟋 YES NAME DE 3. Middle 4. DATE Month Day DECEASED (Type or print) t:()(C(g-t-DEATH 19 6 AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED X last birthday) Months removi Days any WIDOWED DIVORCED Ξ 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT & State, or foreign country) during most of working life, even, if retired) ✓ INDUSTRY 13. FATHER'S NAME MOTHER'S MAIDEN death certificate PAR 15. WAS DECEASED EVER IN U.S. ARMED FORCEST (Yes, no., of unknown) [(If yes give yet of dates of Service) 16. SOCIAL SECURITY NO. 17. INFORMAN Address cramation, CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PHYSICIAN: The law requires that the been signed by the burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) attending physician. DUE TO (Molec) Cardio Vascular diasas Cenditions, If any, which gave rise to immediate 라 DUE TO cause (a), stating the pillor 1 underlying cause last. this certificate has FICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. Health PERFORMED? hospital or NO [ emplusema. 5 20a. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) CERT **t**o detached Dept. (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c, TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) يو Hour a.m. OR ATTENDING F Not While Stat at work | at work p.m. 21. I certify that (1) (this hospital) attended the deceased from DIRECTOR: saw the deceased alive on AM, from the causes and on the date stated above. 3 sho and that death occurred at 22a, SIGNATURE 22b. page ATTENDING PHYS. DIRECTOR PHYS. TO HOSPITAL TO FUNERAL PHYSICIAN'S director, p ADDRESS NAME (Type) LUMBIA DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) RYMOVAL (Specify) RICKS REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25a VR A15 (4) 20M 1/65

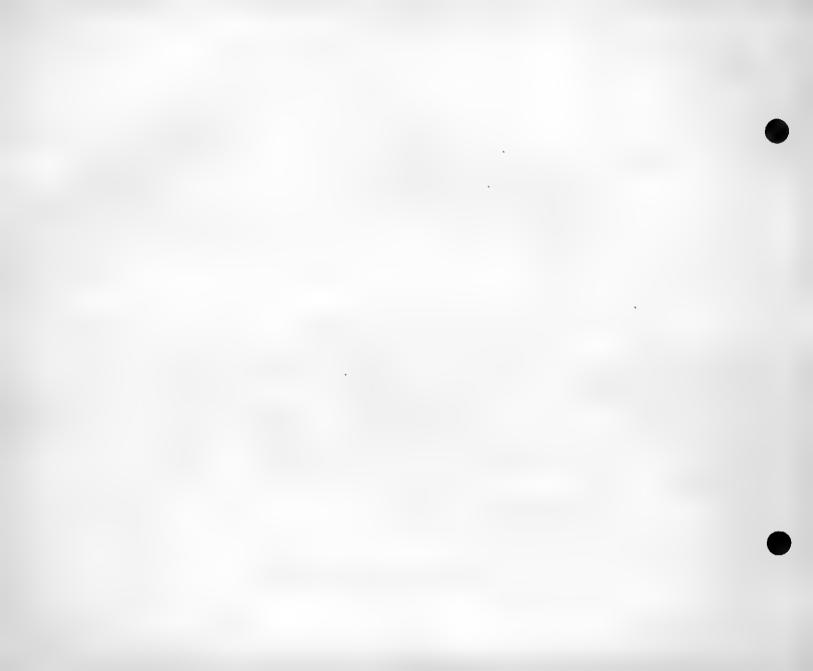


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09834 09839 CERTIFICATE OF DEATH 24 haurs ofter death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY tely filled in by the fun-then papers Pages 1 within 32 haurs after d Virginia Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest to-39 days Quantico Bethesda (rural) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Quarters 2965-A Naval Hospital NO DE PHYSICIAN: The law requires that the death certificate be executed within 3. NAME OF Middle First 4 DATE rsician and campletely please remave carbon last Month Dov Year DECEASED 19 67 PACK Sue July and in any event, (Type or pnot) Connie DEATH S. SEX 6. COLOR OR RACE NEVER MARRIED X 9 AGE ( n years 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED last birthday) Months 96 April 2, 1967 WIDOWED DIVORCED Cauc Female 10o. USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** TISA Quantico, Virginia 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remayal. Lillian Killinger Wallace L. Pack 17 INFORMANT Quantico 15. WAS DECEASED EVER IN J.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO Virginia permit. (Yes, no, or unknown) (If yes give war or dates of service S/SGT Wallace L. Pack, USMC, Quarters 2965-A No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

Letterer-Siwe's INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit p Disease IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO ed far use as the t af Health priartab stating the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES K NO [ 20a ACCIDENT WAS INDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH TO FUNERAL DIRECTOR: After this certification of the state of the stat (IF FITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg , etc.) at work at work 21. I certify that (\$\) (this haspital) attended the deceased from May 20, 1907, and that death occurred at ta July , 17 And the date stated obove to July 7 \_, 19.67, that (I) (we) last director, page 3 should should be filed with the 220 SIGNATURE 22b DATE SIGNED MED DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S Naval Hospital, Bethesda, Md. NAME (Type) Jerry J Tomasovic 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION. 23b DATE THEREOF (County) (State) BREMOVAL (Spraty) 7-11-67 Arlington National Arlington, Virginia 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS VR A15 (4) 25M 1/67 Chanes Funeral Home, 7557 Wisconsin Ave., Bethesda, Model



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05843 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY o STATE papers. Pages 1 Jin 72 haurs after MARYLAND The law requires that the death certificate be executed within 24 hours afted b CITY OR TOWN (if outside comparate limit CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town d NAME OF HOSPITAL OR INSTITUTION Of not in hospital, give street oddress? d STREET ADDRESS ON A FARM? filled NO 4 NAME OF remave carban Middie 4. DATE Dov Year DECEASED 0F (Type or print) 055 DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED last birthdoy) Months Doys Hours or removal, and in ony WIDOWED DIVORCED and 10a USJAL OCCUPATION (Give xind of work done 10h KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? attending physician permit. Then please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no. or Jnknown) (If yes give war ar dotes of service 18 CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c) PART 1. DEATH WAS CAUSED BY signed by the burial-transit p IMMEDIATE CAUSE (a) by the hospital ar attending physician. DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the Tept. of Health prior to has been lost. 0.0 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? 125 No \* YES [ certificate 200 ACC DENT WAS UNDERLYING [3] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port I of item IB) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20f. (City or town) (County) (Stote) Hour om. factory, street, office bldg., etc.) at work 2-24, 1956, to 7-21 21. I certify that (1) (this haspital) attended the deceased from . 1967 that (1) (we) last TO HOSPITAL OR ATTEND Page 4 may be retained saw the deceased alive on 7-2/ 19 17, and that death accurred at 11:10 A.M., from causes and on the date stated above 220 SIGNATURE 22b. DATE SIGNED DIRECTOR director, page should be filed 22c. Frysician's 22d. ADDRESS O FUNERAL NAME (Type) J F / 1914 Semi 230 BURIAL CREMATION DATE THEREOF 23d. LOCATION (City or Town) (Stote) REMOVAL (Specify) Herrord Nd 24 FUNERAL DIRECTOR VR A15 (4)



09836

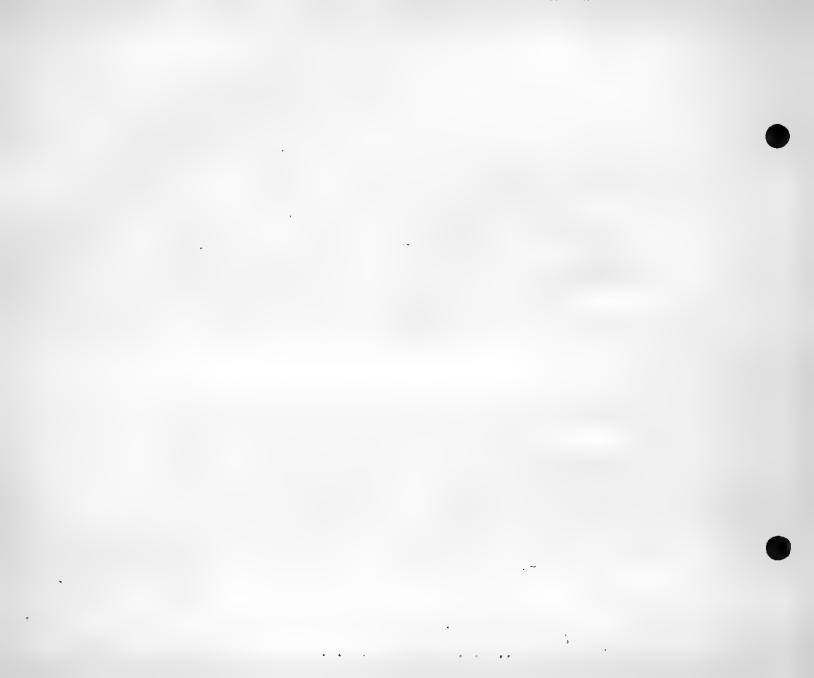
## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09841

1. PLACE OF DEATH o. COUNTY						a. STATE MARYI,AID b. COUNTY LONG GO. ATRY					
b CITY OR TOWN (If autside corporate limits, write RURAL and give negest town) BB F SDA, FURAL			c LENGTH OF STAY IN 16		C. CITY OR TOWN (If outside corporate limits, write RURAL and give CHEVY CHASE				e neorest town)		
	AL OR INSTITUTION (If re	at in hospital, ;	give street address)		d STREET ADDRESS 3317 W. CC	QUFLI	N TERR.			RESIDENCE A FARM?	
3 NAME OF DECEASED (Type or print)	F CATHER	rst TNE	Middle COCKRIL		Lost PANKEY	4. DATE OF DEATH	Manth JUL	Y	Day 24	Year 19 67	
S SEX FENALE	6. COLOR OR RACE  CAUC	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED		B. DATE OF BIRTH  JAN. 8, 1914	9		IF UNDER 1		NDER 24 HRS.	
	Give kind of work dane	10ь. К	IND OF BUSINESS OR		11. BIRTHPLACE (County WASHINGE	& State or for	reign country)		ZEN OF WHA	NI SA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN I		oves				
15 WAS DECEASED EVI	R IN J S ARMED FORCES? (If yes give war ar dates	of service) 16.	SOCIAL SECURITY NO.		NFORMANT CSELL G. PAN		CHLVYAddress		SE, M IN TEI		
Canditions, if ony rise to immedia stating the underlast.	, which gave ) e couse (o), (	(a) <u>CAR</u> (i E TO (b)	CINONA OF 1		CFRVIX (EPII	DERMOI	D)			ND DEATH	
2Do ACCIDENT WA	S UNDERLYING				THE TERMINAL DISEASE CON (Enter nature of injury in	****			19 WAS PERFO YES	ORMED?	
= (II ETITIEK, NOTIFI	1.0	2Dd II White	Nat While		CE OF INJURY (Hame, farm pry, street, affice bldg , etc.)		(Cry or town)	(Coun	ıty)	(State)	
21. I certi saw the d 22a SIGNATURE	fy that (1) (this has eceased alive an_	spital) atten	ded the deceased fr	om d tha	death occurred at,	9_67, to PM MED. DIRECTOR	a JUJ, Y 2/, I, fram causes at	, 19_6 nd on the 22b DAT	e date sta	) (we) last ted abave	
22c PHYSICIAN'S NAME (Type 23a BUR AL CREMAT.	NEIL D.	JACKSO/J	23c NAME OF CEMETE	RY DR	CREMATORY	23d LO	TAL, BETH		MB.	(State)	
24. FUNERAL DIRECTO	Joseph G	awler 8	ARLINGTON Son	NAT al	'L CEMETERY Home 250 RECE	AF BY REGISTR	RLINGTON  AR 256. REGI	STRAR 5 SIG		VA.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the fundirector, page 3 should be detached for use as the burial-transit permit. Then please remaye maken papers. Pages 1 should be filed with the State Dept. of Health prior to burial, cremation, or remayal, and in any eyent, within 72 hours after VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08842 09832 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b county Montgomery o. COUNTY o STATE Montgomery MARYLAND c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate 1 mils, write RURA, and give regrest town) CLENGTH OF STAY IN 16 Chevy Chase Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? and thony event, within 72 Suburban Hospital 4011 Bradley Lane YES NO K NAME OF DATE please remove corbon Middle First Lost Manth Day Year JULY DECEASED GLORIA C. PARANAGUA 1967 (Type or print) DEATH IF UNDER I YEAR IF UNDER 24 HRS DATE OF BIRTH 9. AGE (In years S SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** lost birthdoy) Months Female Caucasian 8/30/97 WIDOWED DIVORCED 12 CITIZEN OF WHAT 10o, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if refired)

NOUS CWITE Home physicion North Wales 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ottending physical lines p burial, cremotian, or removal, Guy Herbert Wood Ethel Murial Brough Wash., D.C. 17, INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no or unknown) (If yes give wor or dotes of service) Mrs.R.L.Kearney, 3426 16th 216-46-5594 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse **DIRECTOR:** After this certificate has been director, page 3 shauld be detached for use os the should be filed with the State Dept. of Health prior to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? CERTIFICATION YES | NO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) 20o ACCIDENT WAS UNDERLYING I OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER' 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or fown) (County) (Stole) 20c TIME OF INJURY Month, Doy, Year Hour 'o.m. foctory, street, office bldg., etc.) Not While at work of work 21. I certify that (I) (this haspital) attended the deceased fram. and that death accurred from causes and an the date stated above saw the deceased alive an 22o 22b. DATE SIGNED 7/8/67 X DIRECTOR 22d ADDRESS FUNERAL Andrew Brennan. M.D. 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23b DATE THEREOF LOCATION (City or Town) (County) BENDYAL (Specify) Waynesboro Pa 7/11/67 Green Hill Cemetery 0 250. REC D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) DATEJU Jos. Gawler's Sons, Inc. Washington, D.C. 25M 1/67



CX.	DIVISION OF SIATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALLIMORE, MARYLAND 21201						
FOR STATE	09830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09843						
MEALIH DANA	PLACE OF DEATH  2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)						
y deloy is 2, and 3 to PM3 Page nortment of ifter deoth.	O COUNTY MONTGOMERY MARYLAND O. STATE MARYLAND 6. COUNTY MONTGOMERY						
deloy and 3 A3 Pa rment ir deot	b CITY OR TOWN (f outside corporate im ts / C LENGTH OF STAY N 1b C CITY OR TOWN (f outside corporate m ts write RURA) and pive a project town)						
delland and M3   M3   Tme	write RUKA, operative negrest fown)						
Par Par	d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address)  d STREET ADDRESS  T e IS RES DENCE						
S D B C	O . O A FARM?						
ges 1, 2, an 1 form PM3 ote Departm	SUBURBAN METROPOLITAN DROVE Kd YES [] NO						
hours after death if it y deloy tem 18 Give Poges 1, 2, and 3 Office olong with form PM3 PagedZwith the State Department event with n 72 hours after death	3 NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED 40 A DATE Month Doy Year						
a ke d	(Type or print) MAURICE WILBERT PARIS DEATH JULY 25 1967						
after 8 GIN 010ng with with	S SEX 6 COLOR OR RACE 7 MARRIED 7 NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years   IF UNDER 24 HRS						
tem 18 Gi Office otoni gadz with	MALC NEGRO WIDOWED DIVORCED 7/27/1914 52 pris Months Doys Hours Min						
hours Item 1 Office	00 US_AL OCCUPATION (G ve kind of work done 10b KIND OF B_SINESS OR 11 BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT						
24 h	during-most of working life, even if retired) NOUSTRY- ( COUNTRY? / C						
hin 24 niners ( poges 1 in ony	13 FATHER'S NAME 14 MCSSENGER US SOUN SIAUNTON - UIT 45 A						
a within in pencil	PHARIAG DARG						
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at Land	15 WAS DECEASED EVER IN L.S. ARMED FORCES? (Yes, ng. prunknown) (f yes give yor or gotes of service)  16 SOC A. SECURITY NO. 17 INFORMANT  Address  Address  Address						
ing edic erm oovc	Ves ARMY Wife. ana faris above						
te should be executed the word "pending" of the Chief Medical obunol-trans.t permit.	AS CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c) )  PART I, DEATH WAS CAUSED BY  NIERVAL BETWEEN  ONST AND, DEATH						
be hief	IMMEDIATE CAUSE (6) COTOTIAL 9 17 CT 1003.3.						
ord ord e Cl	1 4201 DUE TO						
th the ortice	(Conditions, if any, which gave) (b) Cardio Vaseular Disease 420-3						
the state to to be be be a company of the state of the st	rise to immediate couse (a), Storing the underlying couse DUE TO						
ng ng ded	lost. (c)						
certificate should be , writing the word "p arworded to the Chie used as a burial-trans burial, cremation, or	PART I OTHER SIGN F CANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)  19 WAS AUTOPSY PERFORMED?						
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NER: certifi should files t should nt, prio	UNDER OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e P.ACE OF INJURY (Home, form, 20f (City or town) (County) (State)						
MIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Hour o.m. While Not While (foctory, street, office bldg, etc.)						
× # 8 × 2 +	pm. 17   of work   D						
LECTAL EXA ease execute irectar. Poge oined for you IRECTOR. Pog designoted a	21 1 certify that I took charge of the remains described obove, held an Autapsy 🔲, Inspection 💢, Inquiry 🐒, and in my opinio						
G d d e	death resulted fram: Natural couses 🛴 , Accident 🔲 , Suicide 🔲 , Homic'de 🔲 , Undetermined manner 🔲						
MLC.C.A. design	ACTUAL OP & B. O. CHIEF MEDICAL EXAMINER TO 22 DATE SIGNED						
P de la de la si	SIGNATURE OF THE SIGNED M.D. ASSISTANT MEDICAL EXAMINER						
UTY, Property, be be	EXAMINER'S DEPUTY MEDICAL EXAMINER Q 7/25/67						
TO DEPUTY MECTAL E necessory, please exect the funerol director. Po 5 may be retoined for O FUNERAL DIRECTOR: Health or its designate.	NAME (Type)  Address (Street, city, town, or county)						
The Charles	23a. BURIA_ CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote)						
F 2	REMOVAL (Specify), F., 1. 20 101 4 E						
1211	24 FUNERA, DIRECTOR ADDRESS 250, REC'D BY REGISTRAR'S SIGNATURE						

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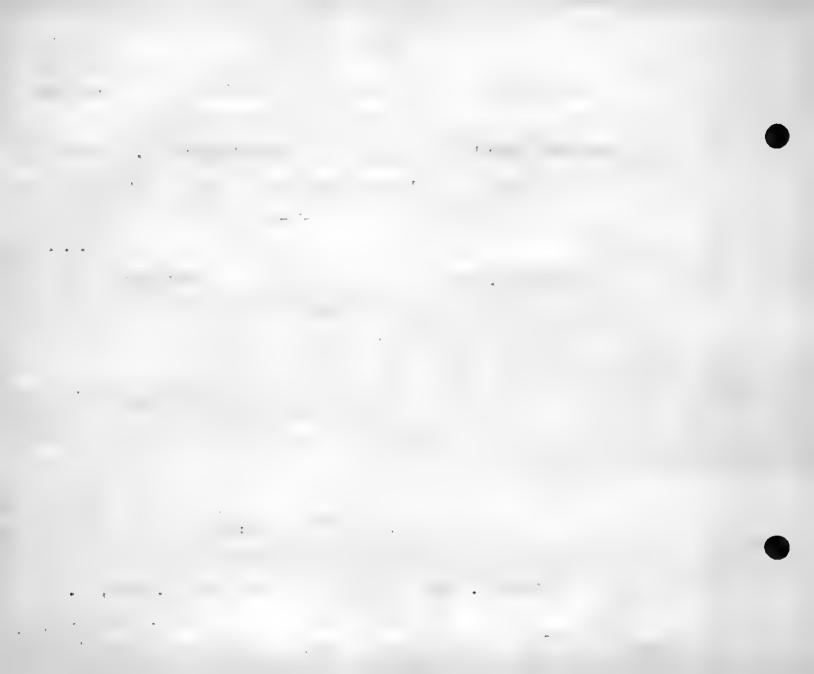
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MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY b. COUNTY Montgomery MARYLAND Maryland Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)

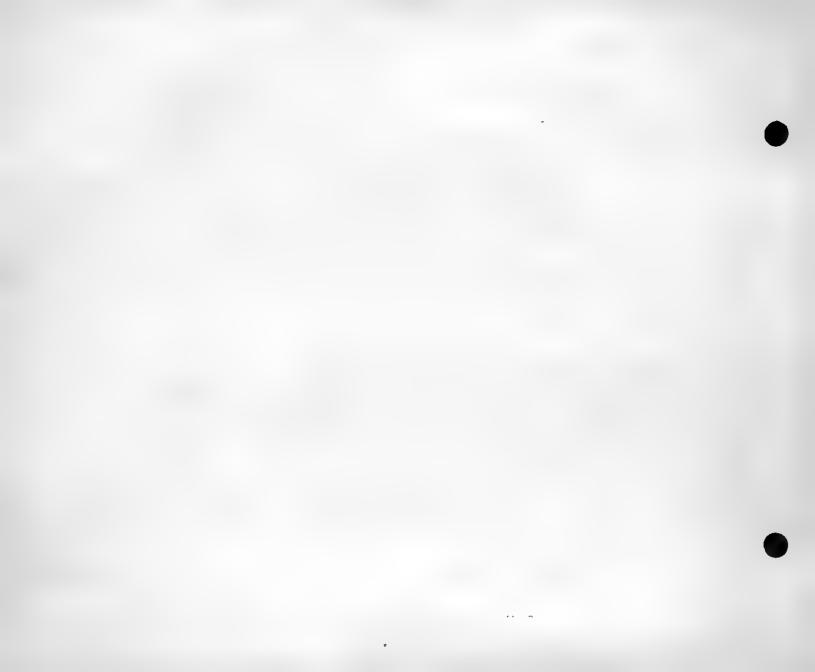
Olney c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town c LENGTH OF STAY IN 16 3wks 3days Silver Spring d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Montgomery General 3632 Gleneagles NAME OF Middle Lost 4. DATE First **DECEASED** Adah Florence DEATH Patterson 6 COLOR OR RACE B. DATE OF BIRTH 9 AGE (in years 7 MARRIED NEVER MARRIED | lost birthdoy) Months WIDOWED 🛧 DIVORCED 3-17-91 puo 100 USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT TOP KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working, I fe, even if retired) INDUSTRY Housewife own home Iowa 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remova Emme Edgar William H. Otto 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) Homer I Patterson 9700 Dyer ST. Elpaso, Dexas 220-34-8577B burial, cremotion, 18. CAUSE OF DEATH (Enter only one couse per line (on(a), (b), and (c))
PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (6) DUE TO Conditions, if only, which gove ? rise to immediate couse (o), **DUE TO** stoting the underlying couse PART II OTHER SIGNATIONT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 140) Inemia 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of Item 18.) 200 ACCIDENT WAS JNDERLYING E OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or fown) (County) (Stote) Not While foctory, street, office bldg, etc.) of work Not While 2). I certify that (1) (this hospital) attended the deceased from June 17, 19, 67, to July 12, 19, 67, that (1) (we) last saw the deceased glive an July 12, 19, 67, and that death accurred a 2:26A, M, from causes and an the date stated above. 22o. SIGNATURE 22b DATE SIGNED M.D. DIRECTOR 22d ADDRESS 22c. PHYSICIAN S O HOSPITAL NAME (Type) Richard A. Yatles Old Baltimore Rd. Olney. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BUR AL, CREMAT ON, George Washington Riggs Rd. Adelphi 25o, REC'D BY REGISTRAR Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md. DATE JUL



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the almoth certificate be manumed within 24 haurs after death. funeral pup deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY o STATE b. COUNTY ve carbon papers. Pages 1 event, within 72 hours after MARYLAND rainia. b CITY OR TOWN (If ourside corporate limits c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ξ OR INSTITUTION (if not in haspital, give street address) S RESIDENCE ON A FARM? campletely filled NO X YES NAME OF DATE Year Doy DECEASED OF DEATH arah (Type or print) July 196 SEX TIF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years remove lost birthdoy) Months Hours -18-0 WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physicion a during most of working life, even if retired) INDUSTRY 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phys permit Then p burial, cremation, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES 17. INFORMAN 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), PART I. DEATH WAS CAUSED BY signed by the c burial-transit p IMMEDIATE CAUSE O HOSPITAL OR ATTENDING PHYSICIAN: The law requires th Page 4 may be retained by the haspital or ottemaling physician DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stoting the underlying couse director, page 3 should be detoched for use as the should be filed with the State Dept. of Health priar to this certificate has been lost. WAS AUTOPS) PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVENIN PART TO NO 200 ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part L of Part 1 of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month Doy, Year (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg, etc.) Not While ot work ot work O FUNERAL DIRECTOR: After 21 I certify that (I) (this hospital attended the deceased from saw the doceased give on and that death accurred at 122 M, fram causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED STAFF ATTENDING MD DIRECTOR PHYS 22d. ADDRESS? 22c. PHYSICIAN'S NAME (Type) 7030 BURIAL CREMATION NAME OF CEMETERY OR CREMATORY 23d .OCATION (City or Town) (County) (Stote) REMOVAL (Specify) 24. FUNERAL DIRECTOR 2Sb REGISTRAR'S SIGNATURE BY REGISTRAR VR A15 (4) 25M 1/67 1967

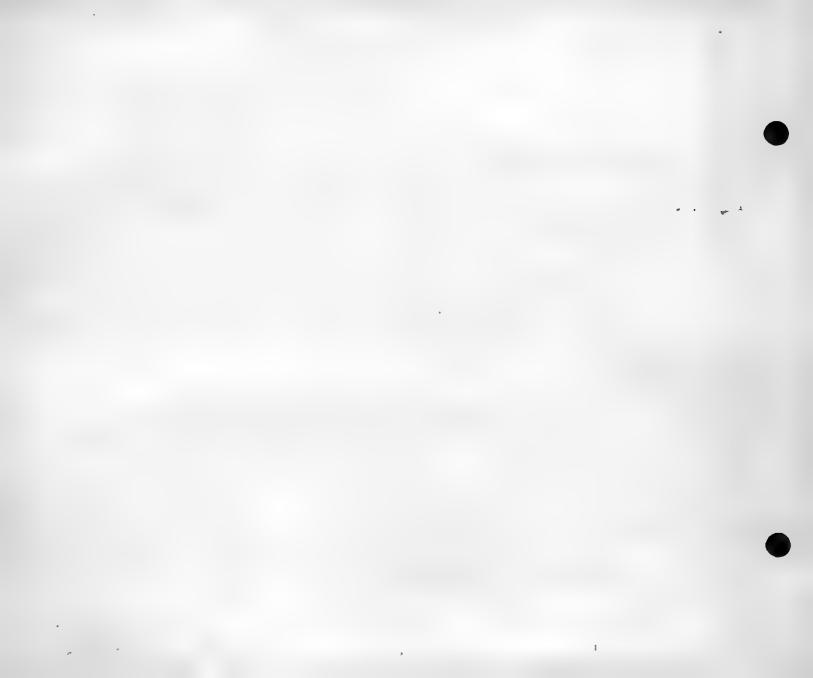


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09846 83841 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY onigomen MARYLAND b. CITY OR TOWN (If outside corporate limits, with RHRAL and give neetest town) outside corporate limits, write RURAL and give nearest frown CLENGTH OF STAY IN 16 popers. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? d STREET ADDRESS YES DATE NAME OF Last Year DECEASED (Type or print) DEATH (In years S. SEX 7. MARRIED **NEVER MARRIED** DATE OF BIRTH t birthdoy) Months Hours DIVORCED and in ony WIDOWED 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) 100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House WIFE 14 MOTHER'S MAIDEN NAM 13. FATHER'S NAME burial, cremation, or removal, Unknown 16. SOCIAL SECURITY NO 17 INFORMAN (If yes give wor or dates of service) IONE 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY RONCHOPNEUMON IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to mmed ate couse (a), DUE TO stating the underlying couse os the ARTERIOSCLEROTIC PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ILO WAS AUTOPST PERFORMED? After this certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (Eity or town). (County) (Stote) 20c TIME OF INJURY Month, Doy, Year MED Hour o.m. factory, street, office bldg., etc.) Not While 21. I certify that (1) (this hespital) attended the deceased from MARCH 30, 1967, to JULY 1967, that (I) (we) las 30 1967, and that death occurred of 2:30 AM, from causes and an the date stated above som the deceased alive on www. TO FUNERAL DIRECTOR: 22b. DATE SIGNED 22d SIGNATURE **ATTENDING** STAFF DIRECTOR M.D. PHYS director, page should be filed HYSICIAN S Robert Del Ray Ave Bethesda, Md 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b DATE THEREOF (County) Gate of Heaven Silver Spring Maryland 7-3-67 250. RECD BY REGISTRAR Pumphrev VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09842 09847 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY o STATE b. COUNTY Monte omery
b. CITY OR TOWN (f autside corporate limits, write RURAL and give nearest tawn) MARYLAND Maryland Montgomery

C CITY OR YOWN (# outside corporate hmits, write RDRAL and give nearest town) Maryland C LENGTH OF STAY IN 15 Takoma Park 17\_days Talioma Park d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS IS RESIDENC pape ON A FARM ₩0 WITTE Washington Saniatarrium and Hospital 617 Elm Avenue YES 3. NAME OF carban Middle Last 4 DATE Manth Year DECEASED 67 (Type or print) Povnter DEATH July 19 IF UNDER 1 YEAR 8 DATE OF BIRTH 9 AGE (In years IF JNDER 24 HR 7 MARRIED NEVER MARRIED last b "nday) Months Hours WIDOWED DIVORCED 12-20-93 white male 10a USUA, OCC. PATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Retired
13. FATHER'S NAME America Kentucy burial, cremation, or removal, IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMAN (Yes, na, ar unknown) (If yes give war or dates of service) Patient's chart signed by the c burial-transit pe 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ONSET AND DEATH ar attending physician. DUE TO Canditians, if any, which gave ) rise to immediate cause (a), stoting the underlying cause the QS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED 19 WAS AUTOPSY PERFORMED? 20o ACCIDENT WAS UNDERLYING [ 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18 by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20c TIME OF NIJRY Month, Day Year (City or fown) (Caunty) (State) factory, street, affice bldg., etc.) Hour o.m. Not While **DIRECTOR:** After at work L at work 21. I certify that (1) (this haspital) oftended the deceased from July 19.65 to be retained and that death accurred at Hime M, fram causes and on the date stated above. saw the deceased alive an 22o. SIGNATURE STAFF PHYS DIRECTOR PHYS director, page shauld be filed 22d ADDRESS TO FUNIRAL 4830 23b DATE THEREOF 230 BURIAL CREMATION. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) (State) (County) BALTIMORE NATIONAL 24 FUNERAL DIRECTOR **ADDRESS** REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 GASCH'S HYATTSVILLE, MARYLAND



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09843 3848 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. by the funeral Pages 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. COUNTY **5 COUNTY** Montgomery Hontgomery MARYLAND b CITY OR TOWN (If outside corporate amits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Olney 16 days Sandy Spring, Md. papers d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? completely fittled Box 81 YES NO Montgomery General NAME OF M Middle Lost DATE Ogy Year DECEASED 1967 Pratt Bessie July CO (Type or print) DEATH and in any event, S. SEX 6 COLOR OR RACE IE UNOER I YEAR IF UNDER 24 HRS OATE OF BIRTH AGE (In years 7 MARRIED **NEVER MARRIED** Months iest birthdoy) 8-6-92 Doys Hours ⊽emale Negro WIDOWED X X DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY physician USA Maryland Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. George Jackson Margaret Hopkins 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for o), (b), and burial-transit PART ! OFATH WAS CAUSED BY IMMEDIATE CAUSE (o) ģ Page 4 may be retained by the hospital or attending physician DUE TO signed Conditions, if any, which gave rise to .mmediate couse (a). DUE TO stating the underlying couse this certificate has been be aetached far use as the State Dept. af Health priar to last SIGNIFICANT, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION SIVEN IN PAR 19. WAS ALTOPSY PERFORMED? 200 ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Port I or Port II of item 18.) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om foctory, street, office bldg, etc.) Not While of work 21. I certify that (I) (this hospital) extended the deceased from 7 ta , 19 that (I) (we) last 5.15 mmram causes and an the data stated abave. that (I) (we) last shauld and that death accurred at, saw the deceased alive 22o. SIGNATURE MEO. DIRECTOR STAFF director, page 3 shauld be filed v M.D PHYS 22c PHYSICIAN'S TO FUNERAL NAME (Type) Dr. Charles Ligot 230 BUR AL, CREMATION 23b OATE THEREOF NAME OF CEMETERY OR CREMATORY 23d (County) (Stote) REMOVAL (Specify) 7/22/67 **BURIA** SANDY SPRING CEMETERY ADDRESS 25o. REC'O BY REGISTRAR PUNERAL DIRECTOR 25b REGISTRAR DATUL 24 1967 ROCKVILLE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH funeral 1 and 2 ter death requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fived, if institution. Residence before admission) o. COUNTY rely filled in by the fune room papers Pages 1 a MARYLAND b CITY OR TOWN (If autside corparate I mits, CLENGTH OF STAY IN 16 ( CITY OR TOWN ( I gutside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Washiniat OR INSTITUTION (If not in haspital give street address) NAME OF 4 DATE Year Month DECEASED URVIS 0.7 BLAKE DEATH AGE (In years IF UNDER SEX B DATE OF BIRTH NEVER MARRIED MARRIED lost birthdoy) Months 1-5-85 Cave WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 1Do USUAL OCCUPAT ON (Give kind of work done 12 CITIZEN OF WHAT 1) BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY ottending physician permit. Then please SUPT NUISING Edocation Weter town NURSING 14. MOTHER'S MAIDEN NAME burioi, cremation, or removal, BLAKE ARTHUR J. FLLEN IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, na, or unknown) [(If yes give wor or dates of service) NURSING HOME -60-6434 UNKNOWN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I DEATH WAS CAUSED BY-NYERVAL BETWEEN ONSET AND DEATH Myocardia IMMEDIATE CAUSE (o) Canditions, if any which gave rise to immediate cause (o). DUE TO stating the underlying cause 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO X ٥ 2Do ACC DENT WAS UNDERLYING . 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Doy, Year Hour a.m. 20d INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (County) (State) Not While factory, street, office bldg., etc.) ot work 21. I certify that (1) (this hospital) attended the deceased fram\_ Man 1967, that (1) (we) last MAY 30, 1967, and that death accorred at 200 MM, fram causes and on the date stated above. saw the deceased alive an\_ 22b DATE SIGNED 220 SIGNATURE MED. DIRECTOR M.D. 22d ADDRESS NAME (Type) 234 RED BANK, N. 23c NAME OF CEMETERY OR CREMATORY DATE THEREOF (County) (State) REMOVAL (Specify) FAIR VIEW 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR DATE JUL VR A15 (4) JOSEPH GAWLER'S SONS WASHINGTON, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09845 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 isours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY MONTGO MERY o. STATE b. COUNTY MARYLAND MONTGOMERY MARYLAND b. CITY OR TOWN (If autside corporafe limits, c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) JILVER SPEING. 3 MONTH. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give steet oddress). d. STREET ADDRESS e. IS RESIDENCE within 72 h ON A FARM? Greeneuy 2105 GRENERY 2105 00 Ab 302. NAME OF corbon Middle 4. DATE Year compretely DECEASED OF DEATH July ANDERSO N QuiNLAM. TRACE 1967 (Type or print) SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR I IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Novomber 12, 1906 WHITE any WIDOWED DIVORCED VIS. 10o. USUAL OCCUPATION (Give kind of work done 10b; KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?USA during most of working life, even if retired) INDUSTRY and CHICAGO, Illinois HOUSE OVIPE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ANDREW Anderson PIHLO Siane 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service) INFORMANT 16. SOCIAL SECURITY NO. Address Greenery Lane 2105 nlan 0 218-56-5544 cremption, 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH buriol-transit MEDIASTINA IMMEDIATE CAUSE (o) be retained by the hospital or attending physicion. DUE TO burial, 1-3 HONTHS Conditions, if ony, which gove THROM BOSES rise to immediate cause (o), DUE TO stoting the underlying couse prior to Days 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 北方 YES [ NO certificate 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port | or Port || of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While , 19,67, ta July 22, 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased from APRIL 27 with the July 15 1967, and that death accurred at 830P M, fram causes and on the date stated above. saw the deceased alive on. 22o. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS GRAZIANI NAME (Type) 140. 10101 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Gate of Heaven Cemetery Silver Spring Maryland 9 250. REGID BY REGISTRAR 8434 Georgia Avenue DATE Pumohreu. Inc. Silver Spring.

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- ~ -	CERTIFICATE OF DEATH	D.S.
by the form of Pages K and ours offer death	1. PLACE OF DEATH O. COUNTY  Lontgomery  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence be be COUNTY by C	efore admission)
s off	b. CHT OK TOWN (IT outside carparate limits, write KURAL and give necessary).	arest town)
ours. Phour	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d. STREET ADDRESS	T . IS DESIDENCE
A DIG	11604 Georgia Avenue 11604 Georgia Avenue	e. IS RESIDENCE ON A FARM? YES NO
Within within	3. NAME OF First Middle Lost 4. DATE Month DECEASED (Type or print) James Genry Quinn DEATH July 23	Doγ Year 3 19 67
e executed within 2 and completely filled i remove corbon paper on ony event, version 72	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR MARRIED DO) MALL Q 1800 Just birthdoy) Months Doy	AR   IF UNDER 24 HRS.
te be ex ion and ose rem nd in on	100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Purchasing Haent  WIDWED DIVORCED 7.89 75.  100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  LINDUSTRY  Conn.  Conn.	OF WHAT
hysical ple	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
cert ng pl Ther	James Quinn Louise Auger	
deoth trendir ermit. in, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (If yes give wor or dotes of service) (Yes, no, or unknown) (Y	ше
NDING PHYSICIAN: The low requires that the death certificate be executed within ad by the hospital or attending physician.  After this certificate has been signed by the attending physicion and completely filled be detached for use as the buriol-transit permit. Then please remove corban per state Dept. of Health prior to buriol, cremation, or removal, and in any event, were the state Dept.	PART I. DEATH WAS CAUSED BY:  18/0  IMMEDIATE CAUSE (o)  DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse lost.  (b)  Cancer of Bladder with Inelastases  (c)	INTERVAL BETWEEN ONSET AND DEATH
The rate e has ouse or outh pr	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO TO
TO HOSPITAL OR A1-ENDING PHYSICIAN: The low re Poge 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	200. ACCIDENT WAS UNDERLYING  200. TIME OF INJURY MADEL EXAMINER)  200. TIME OF INJURY Month, Doy, Yeor  Hour o.m.  200. INJURY OCCURRED  200. PLACE OF INJURY (Home, form, Hour o.m.)  200. County)	
NING PHYSICIAL by the hospital fer this certifica be detached for state Dept. of He	p.m. 19 otwork L atwork L	(State)
SADIII OR: Aft ould be the St	saw the deceased alive on 7-23 1967, and that death occurred at 5:30p M, fram causes and on the d	
OR AN-YNE be retained DIRECTOR: A le 3 should ed with the	220. SIGNATURE  M.D. ATTENDING MED. STAFF 122b. DATE SI PHYS. DIRECTOR PHYS. 17-23	
SPITAL 4 moy VERAL I for, pog	22c PHYSICIAN'S NAME (Type) Morris Perry, M.D. 22d. ADDRESS 11602 Georgia Avenue, Silver S	Spring, Md
O HOSPITAL Poge 4 moy O FUNERAL director, poi	230. BURIAL, CREMATION, PEMOVAL (Specify)  Survey: Parklawn Cemetery Rockville. Maryland	1
VR A15 (4) W	24. FUNERAL DIRECTOR John Shaw 8434 ADDRESS raia Avenue 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNAL WARNER E. Primphrey, Inc. Silver Spring, Md. DATEJUL 31 1967	Judge

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